

WY
108
qN556m
1949

MANUAL
for
PUBLIC HEALTH NURSES





NLM 05285980 6

NATIONAL LIBRARY OF MEDICINE

ARMY MEDICAL LIBRARY

FOUNDED 1836



WASHINGTON, D.C.

STATE OF NEW MEXICO
DEPARTMENT OF PUBLIC HEALTH
SANTA FE

MANUAL
for
PUBLIC HEALTH NURSES



1500

Issued by
DIVISION OF PUBLIC HEALTH NURSING
1949

STATE OF NEW MEXICO
DEPARTMENT OF PUBLIC HEALTH
SANTA FE

MANUAL

for
WY

108

PUBLIC HEALTH NURSES

9 N556m

8 1949

c.1



1260
Issued by
DIVISION OF PUBLIC HEALTH NURSING
1949

TABLE OF CONTENTS

PART I

GENERAL INFORMATION

FOREWORD
HEALTH DISTRICT MAP
PUBLIC HEALTH NURSING RESPONSIBILITIES IN A COMMUNITY HEALTH PROGRAM

Page

PART II

NURSING POLICIES

A. THE LOCAL HEALTH SERVICE COMMITTEE.....	9
B. LOAN CLOSET.....	9
C. RESPONSIBILITY TO PROFESSIONAL ORGANIZATIONS.....	12
D. UNIFORMS.....	13
E. PROGRAM PLANNING TO MEET COMMUNITY NEEDS.....	15
F. PLAN OF WORK.....	16

PART III

GENERAL NURSING PROCEDURES AND TECHNIQUES

A. SUGGESTED BAG CONTENTS, TECHNIQUE, AND HOME VISIT ROUTINE.....	20
1. Objective.....	20
2. Order of bag contents.....	20
3. Suggested procedure of entering and closing bag.....	21
4. Procedure for care of bag and equipment.....	22
5. Bag set-up.....	23
6. Care of the sick - general nursing care.....	25

ACKNOWLEDGED

PART IV

SERVICES

A. COMMUNICABLE DISEASE CONTROL.....	29
1. NOPHN suggested functions in acute communicable disease control.....	29
2. Home care of communicable disease.....	29
3. Isolation room set-up.....	33
4. Suggested isolation technique.....	34
a. General differentiation from procedure in non-communicable disease.....	34
b. Suggested procedure.....	34
c. Conclusion of visit.....	36
d. Terminal care.....	36
5. Outline for control of communicable diseases.....	37
B. VENEREAL DISEASE CONTROL.....	41
1. NOPHN suggested functions in venereal disease control.....	41
2. Venereal disease control manual for nurses.....	41A
C. TUBERCULOSIS CONTROL.....	42
1. NOPHN suggested functions in tuberculosis control.....	42
2. State of New Mexico laws relating to tuberculosis.....	42
3. Tuberculosis control division.....	42
4. Case finding.....	43
5. Medical care.....	43
6. Department of public welfare.....	44
7. Supplies available for educational programs.....	44
8. Follow-up contacts.....	44
D. MATERNITY SERVICE.....	45
1. Public health nursing functions in maternity.....	45
2. Administration of maternity nursing service.....	46
3. Antepartal service.....	51
a. The antepartal nursing visit.....	51
(1) Suggested outline for content of antepartal visit.....	52A
(2) A suggested form for standing orders in maternity and newborn services.....	53
(3) Procedure for admitting a new clinic patient.....	57
(4) Procedure for initial physical examination.....	58
(5) Procedure for revisit of a patient following registration and initial physical examination.....	59
(6) Suggested form for reporting findings of clinic patient.....	62
4. Postpartal service.....	63
a. General policies.....	63
b. Procedure for first postpartal visit.....	63
c. Procedure for second and third postpartal visits - 5th and 9th days.....	65
d. One month postpartal visit.....	65

e. Care of the newborn baby's skin.....	66
f. Formula preparation.....	66
g. Procedure for giving perineal care.....	67
h. Procedure for home attendant who gives perineal case.....	68
i. Procedure for one month clinic examination of mother.....	68
j. Procedure for three month clinic examination of mother.....	69
5. Premature infant care.....	70
a. General suggestions.....	70
b. Loan kit for nursing care of premature infant in the home.....	71
c. Setting up incubator for home use.....	72
d. Hand washing in the home.....	74
e. Dressing the premature infant.....	75
f. Diapering the premature infant.....	76
g. Diaper care.....	78
h. Bathing the premature infant.....	79
i. Feeding the premature infant.....	81
j. The immediate care of cyanotic infant.....	91
k. The use of portable incubator equipped with oxygen.....	91
l. Suggested form.....	93
(1) Referral card from hospital to local health department.....	93
(2) Summary report sheet from local health department in hospital.....	93
6. Midwifery program.....	94
a. Public health nurse's responsibility in the program.....	94
b. Bag for midwives.....	94
c. New Mexico state regulations governing the practice of midwifery.....	94
d. Supplies.....	94
e. Reports and forms.....	94
f. Content of classes for midwives.....	95
g. Diagram - set-up for midwife home delivery.....	97
h. Standard equipment for the midwife bag.....	98
E. CHILD HEALTH SERVICE.....	99
1. NOPHN suggested functions in the infant and preschool child service.....	99
2. The nurse's responsibilities in the child health service.....	99
3. The home visit.....	100
4. Suggestions to the public health nurse.....	100
5. The child health conference.....	100
6. Conference quarters.....	101A
a. Diagram - desirable arrangement of rooms.....	101A
F. SCHOOL HYGIENE SERVICE.....	102
1. NOPHN suggested functions for the school child.....	102
2. Program administration.....	103
3. Professional guidance and responsibilities.....	103
4. Program planning.....	103
5. School nursing procedures.....	104

	<u>Page</u>
G. ADULT HYGIENE.....	104
1. NOPHN suggested functions for adult health supervision.....	104
2. NOPHN suggested functions in industrial nursing.....	104
H. MORBIDITY SERVICE.....	105
1. NOPHN suggested functions for non-communicable disease.....	105
2. Treatments.....	105
a. Medical orders.....	105
b. Family responsibilities.....	105
c. Nurse responsibilities.....	106
d. Procedure techniques.....	106
(1) Enema.....	106
(2) Colon irrigation.....	106
(3) Colostomy irrigation.....	107
(4) Vaginal douche.....	107
(5) Catheterization.....	107
(6) Bladder irrigation.....	109
(7) Ear irrigation.....	110
(8) Intramuscular and hypodermic injections.....	110
(9) Dressings.....	111
3. Selected diseases and conditions.....	112
a. Aging (geriatrics).....	112
b. Brucellosis (undulant fever, malta fever).....	113
c. Cancer.....	115
d. Diabetes mellitus.....	116
e. Heart disease.....	116
f. Multiple sclerosis.....	117
g. Rheumatic fever.....	118
h. Safety.....	119
I. CRIPPLED CHILDREN'S SERVICES.....	121
1. Administration.....	121
2. State staff.....	121
3. Objectives.....	122
4. Eligibility for care.....	122
5. Program for specific care.....	122
6. Functions and responsibilities of public health nurse.....	123
7. Management of itinerant clinics.....	126
8. Brace instructions.....	129
9. Orthopedic terminology.....	130
J. GENERAL SANITATION.....	136
K. PROTECTION OF FOOD AND MILK.....	136
L. LABORATORY.....	137
1. Interpretations.....	137
2. Storage of laboratory containers.....	138
3. Collection of specimens.....	138
M. MENTAL HEALTH SERVICE.....	145

PART V

TECHNIQUES

A. BLOOD PRESSURE TECHNIQUE.....	147
B. AID FOR FROZEN SYRINGES.....	149
C. VISION TESTING AND EYE INSPECTION.....	149
D. HEARING CONSERVATION PROGRAM AND PURE-TONE AUDIOMETER TECHNIQUES.....	149
E. STANDING ORDERS.....	152
1. General suggestions.....	152
2. Immunization procedures.....	153
3. School health service - standing orders.....	158
4. Dysentery control program.....	158
5. Suggested treatment of impetigo neonatorum.....	158
6. Impetigo (contagiosa).....	159
7. Ringworm.....	159
8. Scabies.....	159
9. Treatment for head lice (pediculosis).....	160
10. DDT (dichloro-diphenyl-trichloroethane).....	161
F. STERILIZATION INFORMATION.....	164
G. THERMOMETER TECHNIQUE.....	165
H. URINE SPECIMEN.....	166
I. URINALYSIS TESTING TECHNIQUES.....	170
J. RABIES.....	170
K. ENTEROBIUS VERMICULARIS (pinworm, seat worm, thread worm).....	173

PART VI

FORMS, RECORDS AND REPORTS WITH DIRECTIVES FOR THEIR USE

A. GENERAL SUGGESTIONS.....	176
B. CODE FOR DAILY REPORT.....	177
C. DAILY REPORT.....	179
D. SCHEDULE FOR THE MONTH (ITINERARY).....	181
E. INSTRUCTIONS FOR SPECIAL TABULATIONS AND INTERPRETATION OF SUPPLEMENTAL PAGES FOR ALL NURSES' MONTHLY REPORTS INCLUDING SCHOOL ACTIVITIES.....	182

F. SUGGESTIONS TO NURSES FOR WRITING QUARTERLY NARRATIVE REPORTS...	186
G. VISIT PLAN.....	187
H. INDEX CARD.....	187
I. ACTION REPORT FORMS.....	190
1. Action report.....	190
2. Teacher's referral to public health nurse.....	191
3. Referral to physician.....	192
J. NOTICE TO PARENTS.....	193
K. FAMILY SERVICE FOLDER.....	194
L. FAMILY NURSING VISIT RECORD AND CONTINUATION RECORD.....	200
M. RECORDING SERVICES (SUGGESTED GUIDE).....	203
N. IMMUNIZATION RECORD.....	211
O. COMMUNICABLE DISEASE FORMS.....	213
1. Original report card of communicable disease No. 16-10392....	213
2. District communicable disease report card (salmon color)....	214
3. Communicable disease report card No. 16-10360.....	216
4. Epidemiological record (pink form).....	218
5. Warning placard.....	221
P. PHYSICIANS INITIAL AND PERIODIC REPORT OF TUBERCULOSIS CASES...	223
Q. MATERNITY FORMS.....	225
1. Maternal and child health clinic slip.....	225
2. Maternity record.....	227
3. Clinic appointment card.....	239
R. MIDWIFE SERVICE CARDS AND FORMS.....	240
1. Midwife record.....	240
2. Midwife notice that she has been engaged to attend a maternity patient.....	244
3. Statement of medical examination.....	245
4. Midwife notice of delivery to local health department.....	246
5. Midwife call for assistance form.....	247
6. Midwife annual report.....	248
S. NOTIFICATION OF BIRTH REGISTRATION.....	249
T. CLINIC APPOINTMENT POSTAL CARD.....	251
U. WELL CHILD CLINIC RECORD.....	252
V. NEW MEXICO ELEMENTARY CUMULATIVE RECORD.....	258

W. CRIPPLED CHILDREN'S RECORDS.....	259
1. Referral form CCS 33-R.....	259
2. Report of public health nurse CCS-10.....	261
X. LABORATORY.....	262
1. General suggestions.....	262
2. Bacteriologic and serologic examinations.....	262
a. Wassermann.....	262
b. Agglutination tests.....	264
c. Malaria.....	264
d. Diphtheria.....	265
e. Feces.....	265
f. Gonococcal.....	266
g. Rabies.....	267
h. Sputum.....	267
i. Urine.....	268
Y. TEAMWORK - AN EDITORIAL WITHOUT WORDS.....	269

PART I

GENERAL INFORMATION

FOREWORD

HEALTH DISTRICT MAP

PUBLIC HEALTH NURSING RESPONSIBILITIES
IN A COMMUNITY HEALTH PROGRAM

FOREWORD

The guiding policies in this manual have been developed by all nurses participating in the public health program in New Mexico. We have consulted and quoted many authorities in the preparation of this material and we gratefully acknowledge their contributions.

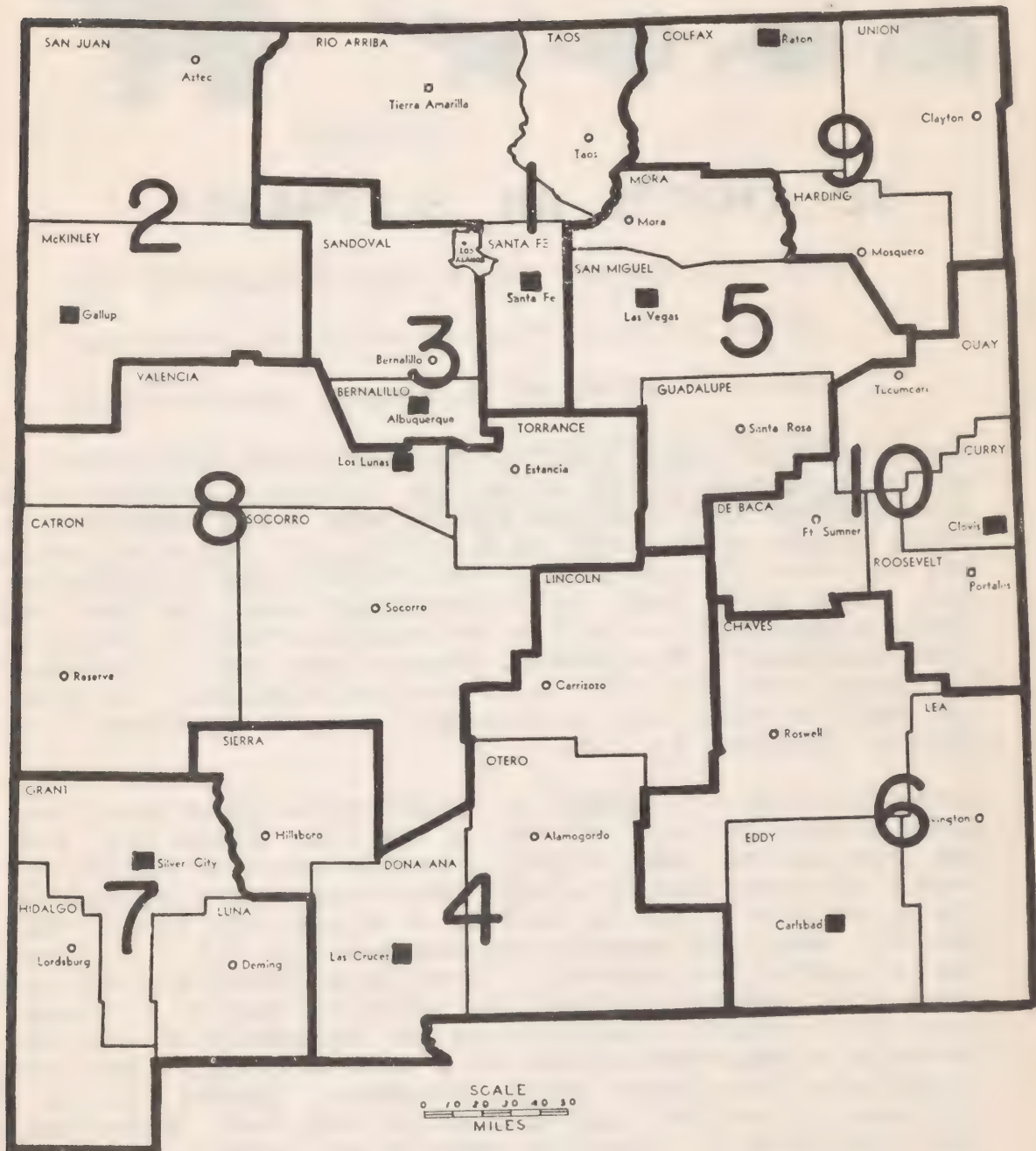


SO THAT'S AN ELEPHANT!

Summertime is circus time in the good old U.S.A., with sawdust and pink lemonade, side shows and tightrope walkers -- added to the heat and that peculiar golden haze which fills the atmosphere in any circus tent on a drowsy, hot August afternoon. But why does the circus come back to village crossroad and big city alike every year, with almost the same acts that our grandfathers witnessed -- with a few modern trimmings and attempts at "streamlining?" The answer, someone has said, is because there are always some who have never seen an elephant. So mother and dad and the other kids come along, too, to show baby brother what an elephant is like.

Often those of us engaged in teaching the great American public about health get sick of saying the same things over and over and over again. Many a public health nurse or health officer or health educator has scratched the cranium in disgust and sighed for a new idea. But in reality -- a new idea is not what is needed. When the sameness of the job gets a bit exasperating -- just remember the elephant. Every year there are new people who are having health problems who never had health problems. Last year they weren't interested in the rudiments of safe care, or choosing a competent doctor or a safe hospital. This year these things are the closest to their hearts. Babies will be coming the same old way so long as human beings have babies and each new generation of expectant mothers and fathers have the same hopes and fears and desires. Your ageless story is BIG NEWS to them. Keep it up! They cry, "So THAT'S an elephant!" where you would say, "That's just an elephant."

HEALTH DISTRICTS



NOTE: Los Alamos County has been assigned to Health District No. 1.

PUBLIC HEALTH NURSING RESPONSIBILITIES IN A COMMUNITY HEALTH PROGRAM*

The Subcommittee on Functions of the NOPHN Committee on Nursing Administration prepared this statement for public health nursing administrators and others interested in public health nursing, and for employers of public health nurses to guide them in determining which responsibilities in a health program public health nurses can best carry out by reason of their education and experience.

"Public health has made rapid progress since 1900. During the early part of the century major emphasis was placed on environmental sanitation and the control of communicable diseases. For the most part control measures of health departments were restrictive rather than educational, and were directed towards groups rather than individuals. Later, as health programs broadened, attention focused on the education of individuals and families in the prevention of disease. Today the objective of a community health program is to bring to all the people the benefits of modern medical and related sciences, including (1) the care and rehabilitation of the sick and disabled; (2) the promotion of healthful living; and (3) the prevention and control of disease.

"Public health nursing participation is required to put into action almost every phase of the health program. It was the unique contribution of public health nurses that they demonstrated the value of health teaching directed to the individual as well as to the group. Their work proved so beneficial that they are now by far the largest single group of professional workers in the public health field.

"Although at first public health nurses were employed primarily for nursing care of the sick and for such specific programs as tuberculosis control and maternal and infant hygiene, controlled experiments prove that service is most effective when each nurse gives all of the necessary public health nursing care to the families she serves. In addition, as one of the community's professional health workers, she participates in all activities that affect the entire health program.

"Social changes, scientific advances, and the demands of people better informed in matters relating to health - all are factors affecting the extension of public health nursing. This broadening scope requires personnel with a comprehensive educational background. In preparation for their career, public health nurses now acquire a greater understanding of the social sciences and of human behavior, as a basic requirement for competence in the art and science of nursing, including health teaching.

"While the scope of public health nursing is increasing, so are public health nursing responsibilities. These may be grouped under three classifications. All public health nurses whether they are administrators, supervisors, staff nurses, or whether they function in all three

*Reprinted by permission of the National Organization for Public Health Nursing, New York, Public Health Nursing, February, 1949, pp. 67-69.

capacities, may be called upon to carry these out.

"The classifications of responsibilities are:

1. Nursing care and health guidance to individuals and families - at home, school, work, and at medical and health centers.
2. Collaboration with other professions and citizen groups in studying, planning, and putting into action the community health program.
3. Participation in educational programs for nurses, allied professional workers, and community groups.

"1. Nursing care and health guidance to individuals and families - at home, school, work, and at medical and health centers.

The responsibility of public health nursing is to:

- a. Provide on a part-time basis skilled nursing care under nursing direction and give treatment, under medical direction; demonstrate, teach and supervise the nursing care that families, practical nurses, or other workers may assume safely in the absence of the public health nurse.
- b. Guide families to recognize their medical, nursing, and health needs and give counsel appropriate to the situation and the families' recognition of their needs.
- c. Interpret to individuals and families the implications of the medical diagnosis and guide them in carrying out the treatment and regime recommended by the physician.
- d. Guide individuals with social and emotional difficulties to appropriate community agencies when indicated.
- e. Perform, under the direction of a physician, diagnostic tests and preventive immunizations, and interpret the findings of the tests to individuals and families.
- f. Work with families to secure and maintain satisfactory environmental conditions that will prevent disease and accidents.

"2. Collaboration with other professions and citizen groups in studying, planning, and putting into action the community health program.

The responsibility of public health nursing is to:

- a. Participate in finding new and early cases of illness by taking part in the planning and conduct of field investigations, epidemiological studies, and examinations of selected groups.
- b. Share in the collection, analysis, and interpretation of records and statistics significant to the development of needed health services.
- c. Formulate and evaluate an organization's nursing program and procedures to insure economical use of nursing personnel and sound correlation of work with that of other community health and social agencies.

- d. Make periodic cost and time studies to determine if expenditures for nursing are distributed wisely and adequately in relation to the total agency budget and community health needs.
- e. Participate in community planning for immediate and long-term health needs, including the coordination of existing nursing services, and for eradication of social and economic conditions known to contribute to poor health.
- f. Participate in community planning for correlating nursing care in hospitals, clinics, schools, industries, and homes.
- g. Work with citizen groups to develop community participation in public health and public health nursing services.
- h. Participate in programs of public information and public relations for public health nursing and community health.

Participation in educational programs for nurses, allied professional workers, and community groups.

The responsibility of public health nursing is to:

- a. Plan, conduct and evaluate in-service educational programs for public health nurses.
- b. Take part in planning in-service educational programs for other health personnel and for related community agencies - school, hospital, and social welfare organizations.
- c. Instruct community groups in home nursing procedures, maternity care, or other subjects related to family and community health.
- d. Cooperate with schools of nursing and universities in providing and preparing qualified faculty; and in planning and carrying out a program that will promote an understanding of community health among the nursing students and nursing staff.
- e. Participate in plans to provide field practice for students enrolled in university public health and public health nursing programs, and for selected students of schools of nursing.
- f. Share with other personnel of health organizations in providing field observations for students in allied health professions, and provide opportunities for selected visitors to observe public health nursing activities.
- g. Interpret public health nursing opportunities to high school and college counselors, to educational administrators, and to students."

PART II

NURSING POLICIES

- A. LOCAL SERVICE COMMITTEE
- B. LOAN CLOSET
- C. RESPONSIBILITIES TO PROFESSIONAL ORGANIZATIONS
- D. UNIFORMS
- E. PROGRAM PLANNING TO MEET COMMUNITY NEEDS
- F. PLAN OF WORK

PART II - NURSING POLICIES

A. THE LOCAL SERVICE COMMITTEE

1. Organization

- a. The committee is composed of all official and voluntary health agencies in a community, of professional groups such as medical, dental and nursing, civic, religious, fraternal and service organizations
- b. This committee should serve as a cooperative agency for coordination in the field of public health. The community's health needs should be studied and program planning done on a group basis
- c. All public health services should be sponsored by a community group. Periodic meetings should be held with the health department personnel to aid lay members to keep informed on the health department services. This also assists the members in interpreting the services to the community

2. Functions of the committee

- a. Assisting with securing appropriations from the county officials and from other agencies, for the service
- b. Consulting with the professional personnel on the scope of service to be given
- c. Promoting the professional work of the committee
- d. Serving as interpreters of the agency activities to the community
- e. Promoting interest in maintaining professional standards

3. Some specific activities for the committee

- a. Learning the essentials of public health work
- b. Assisting with organizing a public health service
- c. Helping to acquaint the community with services available from the state and local health departments
- d. Organizing classes to be taught by the nurse
- e. Referring patients to available health services
- f. Assisting with organizing and conducting all types of health conferences
 - (1) Assembling equipment
 - (2) Encouraging attendance at conferences
 - (3) Arranging for transportation of patients when needed
- g. Equipping and assuming charge of a community loan closet
- h. Visiting state schools, institutions, etc., when possible, to acquaint themselves with the state's resources
- i. Assisting with clerical work
- j. Arrange for a health library as a part of the public library and school library in the community

B. LOAN CLOSETS

People of many communities have found strategically located sick-

room supplies a great help in time of need. This assembled equipment has been called Loan Closets. A custodian issues needed equipment on a loan basis in the same manner as the librarian issues books. Articles are to be returned in good condition at a stated time. It is important to understand at the onset that these supplies are for everyone's use, and are not an indigent service.

A group of people working together to start a loan closet may be the nucleus of a future local service committee, or the loan closet may be a project of an already organized local service committee.

1. The local group who assumes responsibility for the establishment of a loan closet usually appoints a special committee to arrange for:
 - a. Central location where articles to be loaned may be kept and available on a twenty-four hour basis
 - b. Procuring and replenishing the supplies as the need arises
 - c. Re-laundering linens
 - d. Re-cleaning and sterilizing articles
 - e. Maintaining current inventory of marked items
 - f. Marking linens with India ink, and furniture and utensils with black paint
 - g. Keeping a card index file showing articles loaned; enter on the card the date borrowed, name, address, telephone number of the borrower, items borrowed and the date items are to be returned; borrower is to sign this card; check off on card all items when they are returned
 - h. Furnishing keys to the closet to the chairman of the special committee, the nurse in the district, and the custodian of the closet
2. Committees have been able to secure financial grants or supplies from local civic, fraternal and religious organizations as well as from individuals
3. Suggested contents for a complete loan closet -
Local loan closets should be established to best meet local situations
 - a. Linens - sheets, towels, pillow cases, blankets, night gowns, (adult and children), wash cloths, hot water bottle covers, abdominal binders, washable robes for men, women, and children
 - b. Sickroom and first aid supplies - sand bags, bed blocks, bedpans, douche cans and tips, non-breakable pitchers, enema cans and rectal tips, enameled basins, rubber sheets, rubber rings, medicine droppers, clinical thermometers, hot water bottles, ice caps, bandages, dressings, perineal pads, clean pieces of old wool, linen and muslin material, newspapers, newspaper bed pads, triangular bandages, stupe wringers, bedcradles, bed-

tables, pails with covers, cots, washtubs, and wringers for polio packs

- c. Layettes - diapers, gowns, bands, cotton shirts, blankets (preferably double squares of outing flannel), small soft towels, washcloths, safety pins, baby oil and mild soap. (These should be gifts to the family.)
- d. Clothing - slippers should be given outright. Other clothing should not be accepted for distribution
- e. Diversional therapy materials - magazines, scrapbooks, color books, color crayons, story books, cutout books, to be given as gifts. Washable toys may be loaned.
- f. Aids for the handicapped - crutches, canes, wheelchairs, Bradford frame, fracture and hospital beds
- g. Sterile delivery packages - committee should find out whether the physicians prefer to use paper or cotton packs. If there are many home deliveries in the community, the cotton kit will be more economical but there will be a recurring problem of laundry and sterilizations

(1) Suggested content of cotton delivery package

- (a) Bundle wrapper - 1 yard square - double thickness of material
- (b) 1 gown for doctor
- (c) 1 cord dressing with tape
- (d) 4 gauze squares
- (e) 16 cotton balls
- (f) 4 perineal pads
- (g) 5 towels 16" x 24"
- (h) 2 sheets 72" x 90"
- (i) 1 infant outing or cotton receiving blanket
- (j) 1 diaper to line receiving blanket

4. Care of equipment

It is suggested that these instructions regarding the care of supplies be copied on cards and given with the equipment as it is loaned.

a. Linens (and wool packs for poliomyelitis when ready to return)

(1) Soak in lukewarm, clean water several hours before washing

(2) Wash in hot, clean, soapsuds

(3) Boil for 10 minutes

(4) Rinse in warm water once and in cold water once

(5) Hang in sun from 6 to 12 hours

(6) Iron sheets

(Sheets can be protected from stains by using newspaper pads underneath the patient - especially with bed pan)

b. Bed pan

(1) Always empty pan immediately after it is used and rinse with clean water

(2) Wash once daily in warm soapsuds and rinse with hot water

- (3) Always keep covered with newspaper, or in paper bag
- (4) Before returning, clean as above and boil for 10 minutes
- c. Enema outfit
 - (1) Wash can and enema tip or rectal tube with clean soapsuds and rinse
 - (2) Before returning clean as above and
 - (a) Boil can for three minutes
 - (3) Enema metal clamp
 - (a) Never leave clip fastened between treatments, it will cause rubber to crack; fasten clamp while in use
- c. Hot water bottle
 - (1) When placing near patient, cover with hot water bottle cover provided, turkish towel or pillow case (Rubber next to patient is uncomfortable and may cause a burn)
 - (2) When not in use, blow a little air into bottle and fasten screw top to keep sides from touching
 - (3) Before returning:
 - (a) Wash with warm soapsuds
 - (b) Rinse with plain warm water - dry
 - (c) Blow a little air into bottle and fasten screw top
- e. Rubber sheeting
 - (1) Scrub thoroughly with hot soapsuds
 - (2) Rinse well with clear running water and dry carefully
- f. Bed blocks and bed trays
 - (1) Scrub thoroughly with warm soapsuds
 - (2) Rinse with clear water and dry carefully
- g. For poliomyelitis cases*
 - (1) Wringers and tubs
 - (a) Wash with soap and hot water; rinse thoroughly with hot water
 - (2) Oil silk or waterproof material
 - (a) Wash in hot soapsuds and hang in sun to dry from 6 to 12 hours

C. RESPONSIBILITY TO PROFESSIONAL ORGANIZATIONS

A nurse's membership in state and national organizations publicly expresses belief in her profession. Such affiliations give the nurse an opportunity to share professional nursing advancements in service and education. Every public health nurse should belong to the American Nurses' Association (through her Alumnae and District Associations) and the National Organization for Public Health Nursing.

Each public health nurse is required to comply with the current New Mexico laws regarding nurse registration.

*Refer to A Guide for Nurses in the Nursing Care of Patients with Infantile Paralysis, The National Foundation for Infantile Paralysis Inc, New York

D. UNIFORMS

The Public Health Nursing Section of the New Mexico Public Health Association approved the adoption of the national official public health nursing uniform at the meeting held in Albuquerque, May 21, 1947. The Public Health Nursing Section of the New Mexico State Nurses' Association reaffirmed this decision at their annual meeting held in Santa Fe, October 7, 1948.

The official uniform for nurses employed in public health in the State of New Mexico is the national public health nursing uniform.

Since one of the important functions of a public health nurse's uniform is to identify the nurse as belonging to that nursing service, it is suggested that all members of any local group wear identical uniforms at the same time, for example; seersucker to be worn when seasonal.

Professional grooming is a part of maintaining an acceptable appearance in uniform. It is assumed that all public health nurses will naturally observe the following considerations; body cleanliness, regular use of an underarm astringent, and conservative make-up. Use of the above are necessary for professional appearance, a pattern for good teaching.

The hair should be clean and dressed becomingly. It should never hang below the collar line while on duty.

Particular attention should be paid to the hands, they should be free from cuts and abrasions, the nails even with the finger tips, cuticle smooth and regular, nail polish optional, taking care to keep it smooth, avoid chipping and other irregularities in its use.

Jewelry limited to the wearing of a watch and plain rings.

A supporting type of uplift brassiere is conducive to comfort, health and appearance - it is suggested that a garter type garment be worn to support the hose from a standpoint of the individual nurse's well-being, as well as providing a good example to the patient.

Neutral colored hose are to be worn at all times while on duty, or the use of leg make-up is acceptable if neatly used. NO BARE LEGS.

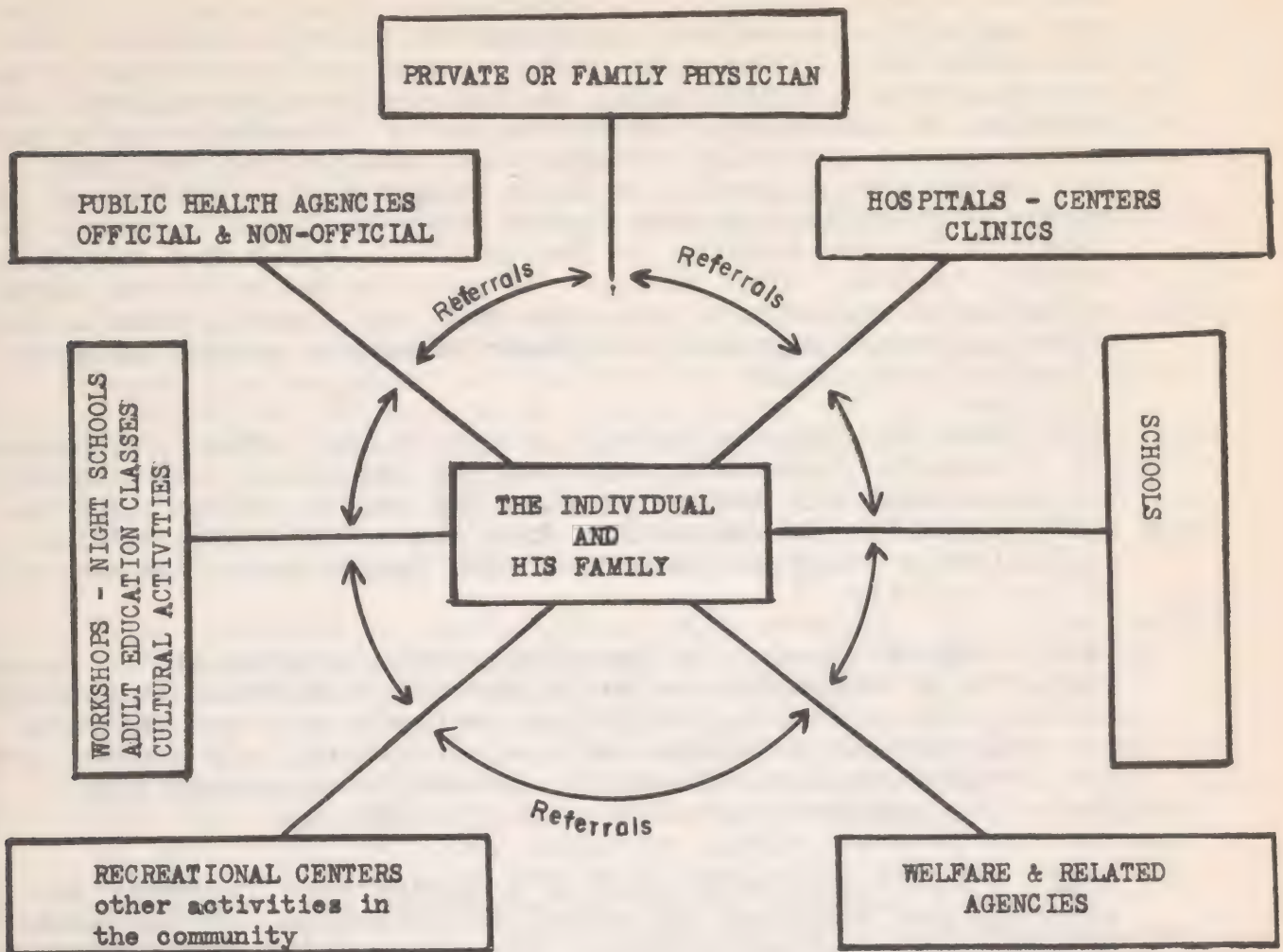
Oxford type shoes are preferable, with a medium, even heel, colors may be black, blue, brown or white. No open toes or heels are to be worn with a uniform. To keep shoes well groomed it is usually necessary to polish them daily.

It is equally important to maintain the appearance of the uniform, it is essential to keep it meticulously clean. This usually means it can be worn one day only, then laundered. Collars and trimmings cannot be worn more than once, with any degree of cleanliness.

The uniform should fit well, neither too tight nor too loose. The length should be that which is most becoming to the individual. The head scarf has been approved as part of the accepted uniform due to the amount of wind encountered here. Hats, if worn, should be tailored. See official hats.

Coats should be tailored and clean, free from lint, dust and animal hairs. The official coat is navy blue.

PROGRAM PLANNING TO MEET COMMUNITY NEEDS



1. Every nurse should have a detailed knowledge of the agencies in her community existing to help the individual and his family. And she should know how to use them!!!
2. Demonstration of bedside care, specific health guidance, instruction for communicable disease control, general health supervision, and general social guidance are available for the nurse to secure for her patients and families.
3. Methods of referral and distribution of responsibility should be known to all nurses.
4. Community nursing as practiced by all agencies should be known to every professional nurse and be interpreted to the entire community by the nurse and by her lay committee, patients and coworkers in other agencies.
5. Relationships should be known for comprehensive community planning. Nurses in one agency should know personally nurses in another agency and other community leaders. (Group meetings, institutes, workshops with nurses from all agencies attending should be planned).
6. Need for less stratification in nursing groups. All have common interests and activities.

F. PLAN OF WORK

"The nurse who carries on a generalized program which includes various nursing services will plan her daily routine so that over a period of time each phase of her work will receive the amount of time corresponding to its relative importance. Such planning is necessary whether the nurse is employed in a one-nurse service covering a county or other geographical unit, or whether she is part of a large organization subdivided into smaller districts. In the latter situation each nurse is responsible for the service in the particular district assigned to her; however, when pressure of work is heavy in one district adjustments are made to equalize the load, and in such a contingency nurses may make visits or otherwise assist in each other's districts.

"The nurse reports to the office once a day, either in person, or, if she is in an outlying area, by telephone. This enables her to receive new calls and plan the day's program. If the nurse is unable to report for duty she notifies her office sufficiently early so that provision can be made for the care of her patients.

"When bedside nursing is included in the program of the agency, the nurse arranges her calls in the order of their importance. Acutely ill patients, postpartum patients, and new patients are seen first. Patients who are not acutely ill and who are visited for surgical dressings, general nursing care, and periodic treatments are seen later in the day.

"When school nursing is part of a generalized program, the schedule for visiting the school is determined by the needs of the total nursing program. The plan will depend on how the nurse can make the most effective use of her time. This will be determined by consultation between the nursing administrator and the school administrator.

"When a generalized program includes both bedside nursing and school nursing, it is impossible to arrange a schedule for visiting the schools the first thing in the morning unless a relief nurse is provided to care for acutely ill patients who must be seen early.

"Because the public in general does not understand the principle underlying nursing techniques in the care of communicable disease, and is therefore fearful that the nurse may carry the disease from one patient to another, it is frequently a practice to visit communicable disease patients after other visits have been made. Frequently, however, these are the most seriously ill patients, and require visits early in the day. It is generally considered safe for the nurse to make these visits at any time of the day without danger to other

*The National Organization for Public Health Nursing, Manual of Public Health, Third Edition, New York, The Macmillan Company, pp 23 - 26

patients, providing communicable disease techniques are rigidly observed. The advice of the medical advisory committee is sought in deciding whether these visits may be made at any time of the day and whether the nurse shall be permitted to do surgical dressings, assist at deliveries, or visit maternity patients during the time she is giving nursing care to patients with scarlet fever, erysipelas, or other streptococcus infections.

"Arrangements should be made so that health supervision calls need not be neglected because of pressure of work. By a careful arrangement of the time of the regular staff and by securing relief nurses in busy seasons, it is possible to cover this essential part of the program. Factors to be considered when planning health supervision calls are: They are made (1) at hours that are convenient for the family (2) at hours that will require a minimum of travel time (3) at times when "not-at-home" visits can be reduced to a minimum.

"The rural nurse working alone will usually find it necessary to limit her work geographically or to limit the types of service given. Frequently, she divides her district into sections according to population and roads, and plans to visit each in rotation. The length of time spent in each and the frequency of visits will be determined by such factors as the size of territory, density of population, and condition of the roads. A local committee member in each section may assume responsibility for receiving calls for the nurse in that area, and for reporting health problems to her. A schedule which is followed carefully day by day and week by week is essential if the nurse is to distribute her services with fairness and impartiality. It is recognized that one nurse is not adequate to carry on a generalized service in a large area. But by a careful arrangement of her program, every part of the territory can be shown what might be possible if there were more nurses. The progress which the nurse makes in educating the community to meet its health problems will depend upon wise discrimination in choosing the community's outstanding needs as the basis for her program and upon skillful interpretation to the community of her method of program-planning...

"...Nurses find it helpful to establish a definite time for individual and group conferences at their headquarters or at a convenient place in their districts. Antepartum patients, certain ambulatory patients, and parents of children receiving health supervision can come to the nurse's office for part of their care or for conferences. This plan encourages them to assume responsibility for their own health, and it also saves the nurse's time. In most instances, office visits should supplement but not replace home visits.

"The character of a public health nurse's work is such that even the most carefully planned day is subject to rearrangement because of emergencies and unforeseen interruptions. This fact must be considered when plans are made regarding appointments for meetings, classes, and individual conferences with physicians and other health or social workers."*

The use of the monthly itinerary and visit plan card are physical aids to work organization. They assist the nurse in planning her program to meet local needs, and in conserving nursing time, energy and mileage.

PART III

GENERAL NURSING PROCEDURES AND TECHNIQUES

A. SUGGESTED BAG CONTENTS, TECHNIQUE, AND HOME VISIT ROUTINE

PART III - GENERAL NURSING PROCEDURES AND TECHNIQUES

A. SUGGESTED BAG CONTENTS, TECHNIQUE, AND HOME VISIT ROUTINE

1. Objective

- a. To give and demonstrate nursing service
- b. To prevent the spread of infection and provide safety for the patient, attendant, family, community and the nurse
- c. To provide for the above with the greatest possible degree of convenience and safety

2. Order of bag contents

- a. In space back of bag lining (rear) place paper apron. Re-snap buttons
- b. From left to right in clean bag area in the rear part of lining:
 - (1) Pencil flashlight
 - (2) Green soap
 - (3) Hand lotion - optional
 - (4) Alcohol - 70%
 - (5) Sterile syringe in case and sterile needles -

One - 2" - 20 gauge	}	
One - 2" - 22 gauge		2 cc. syringe
One - 5/8" - 25 gauge		5 cc. syringe
 - (6) Tongue blades and applicators in case
 - (7) Adhesive wrapped on tongue blades
- c. In left end pocket:
 - (1) Bandage scissors
 - (2) Thumb forceps
 - (3) Hemostat or Kelly forceps
 - (4) Catch baby scales in pocket
- d. From left to right in pockets at front of lining:
 - (1) Mouth thermometer in dry case
 - (2) Rectal thermometer in dry case
 - (3) Emergency thermometer in dry case
 - (4) Eye dropper

{	May be carried in nurse's uniform pocket in summer
---	--
- e. In center of bag:
 - (1) White enamel pan with cover - 1
 - (2) (a) Urinalysis set - Galatest and Albumin
 - (2) Bag of cotton balls
 - (3) Bag containing:
 - (a) Sterile dressings - 4
 - (b) Cord dressings - 4 (2 with and 2 without ties)
 - (c) Silver nitrate ampoules in metal case - 4
 - (d) Bandage - 1 - 2"
 - (4) Metal tape measure
 - (5) In one long bag:
 - (a) Stethoscope
 - (b) Tycos wrapped in paper napkin - held together with rubber band
 - (c) Tourniquet
 - (d) Rectal tube - #30

- (e) French Catheters - #14 and #16
- (f) Small funnel - 1

Note: Numbers 1, 2, 4, 5 and 6 are optional dependent upon standing orders and/or family physician's orders

f. Hand washing compartment

- (1) In newspaper bag place -
 - (Bag to be folded and refilled at close of visit)
 - (a) Paper napkins - 3
 - (b) Paper towels - 2
 - (c) Toothpicks (2) or orangewood stick - 1
 - (d) Shaving cream, liquid soap, or cake of soap in case
- (2) Paper napkins - 10
- (3) Paper towels - 10
- (4) Thumb tacks in metal case - optional

g. On top of contents place folded apron - clean side out

h. Single folds of newspaper - on flaps (under cover) with end of one extending for ease in removing upon entering home

i. Records and literature may be placed on flaps, or may be carried in blue denim bag.

j. Extra supply of newspapers to be carried in car

3. Suggested procedure of entering and closing bag

a. Enter home as a visitor

- (1) Place bag on single fold of newspaper in a safe place, before removing wraps
- (2) The bag should be placed at least three feet from the patient to be out of droplet area
- (3) Remove coat, fold with lining inside, place on a chair away from wall. Hat may be worn while giving care, or place on coat top down
- (4) It is important that the family find you a seat and that they sit down to talk with you - important in building rapport
 - (a) Part of record may be written at this time
- (5) Roll up sleeves
- (6) Snap lid (cover) back,
 - (a) Place set-up with paper waste bag in upper corner
 - (b) Place or take soap and towels to convenient separate hand washing facilities; hand washing set-up at bag on lower corner of bag set-up
 - (c) Apply small amount of soap on hands, use toothpick or orangewood stick to clean under nails, discard toothpick, wash hands. If running water is available, use it. If not, have someone pour water over hands. Avoid washing in basin. Dry with paper towel
 - (d) Put used towel and toothpick in paper bag
- (7) Open flaps and remove apron from bag. Put on apron with the inside fold away from you. Always wear apron when giving any form of nursing care
- (8) Place family folder, referral forms and literature on upper right hand corner of newspaper

- (9) On clean area - napkin, place additional articles needed for nursing service from clean bag area. One napkin at hand washing area with shaving soap, toothpick or orangewood stick, towels upon it for hand washing. Paper bag at both areas. (Note: If not convenient to set-up two clean areas in the home one may be used as in "h")
- (10) Close flaps after all articles have been removed. (if it is necessary to remove other articles after starting care of the patient, wash the hands before opening the flaps)
- b. Upon completion of care
 - (1) Wash hands and dry with paper towel and discard toothpick and towel in paper bag
 - (2) Open bag
 - (3) Replace articles in bag. Be sure they are clean and dry to protect bag lining. If Tycos was used, wrap in a paper napkin and re-use rubber bands. Then close clean area
 - (4) Fold paper bag and pack for next visit
 - (5) Open hand washing area and replace shaving soap
 - (6) Close hand washing area
 - (7) Remove apron, fold with contaminated side in and place in bag
 - (8) Place folds of newspaper under cover
 - (9) Close and fasten bag
 - (10) Record pertinent facts of visit
 - (11) Slip record under cover
 - (12) Put on wraps
 - (13) Remove bag from newspaper
 - (14) Fold upper part of newspaper over waste bag and the family will complete folding and take care of disposal

Note: In car remove record - complete recording - place in denim bag - place record in back of records in front space

4. Procedure for care of bag and equipment

- a. The bag is not to be placed on the floor at any time either in the home, car or office
- b. The inside of the bag is considered a clean area, and the nurse is responsible for keeping the bag lining clean
- c. Aprons and linings should be changed according to need. When in daily use, the apron should be changed at least twice a week
- d. Bottles should be neatly labeled
- e. Tycos should always be wrapped in a paper napkin. The Tycos napkin may be used on the patient's arm to protect the Tycos
- f. Check supplies daily and add any additional items needed for the care and replenish as necessary, i.e., glass cylinder for urinalysis, rubber goods, etc.
- g. Equipment used in giving care is always to be washed in soapsuds, rinsed and boiled five minutes after use. Instruments are to be oiled frequently

5. Bag Set-Up

Paper apron — 1 — behind lining — buttons snapped

Pencil flash- light	Green Soap	Hand Lotion	Alcohol	2cc Syringe & Needle (Sterile)	5cc Sterile Syringe & Needle	Tongue blades & applicators in case
---------------------------	---------------	----------------	---------	---	---------------------------------------	--

Scissors	Bag of cotton balls
Thumb forceps	
Hemostat or	
Kelly forceps	
Catch baby scales	
in pocket	

Medicine Dropper	Folded newspapers on top of flaps with end extending to facilitate taking paper out on enter- ing home
(Urinalysis set	
(Galatest	
(Albumin test	
(PD & S Co.	
(Tycoon in napkin	
(with rubber band	
(Stethoscope	
(Tourniquet	
(Rectal tube — 1	
(Funnel	
No. 14 — 1	} French Catheter
No. 16 — 1	

(Bandage	Enamel basin with cover
(Sterile dressings	
(Silver nitrate	
(Adhesive on	
(Tongue blade	
(Tape measure	
(tongue blade	
(Cord dressings	
2 with tape	In long muslin case
2 without tape	

HAND WASHING COMPARTMENT

Records may be carried in blue denim bag, or on top of flaps, or in front between bag lining and outside of bag by leaving each end snapped and center unsnapped		
In newspaper bag:		
(1) Paper napkins	—3	
(2) Paper towels	—4	
(3) Toothpicks or orangewood stick	—2	
(4) Shaving cream		
(5) Extra paper bag		
	Paper towels — 10	Paper napkins — 10
		Thumb tacks (optional)
		—or carried in glove compartment

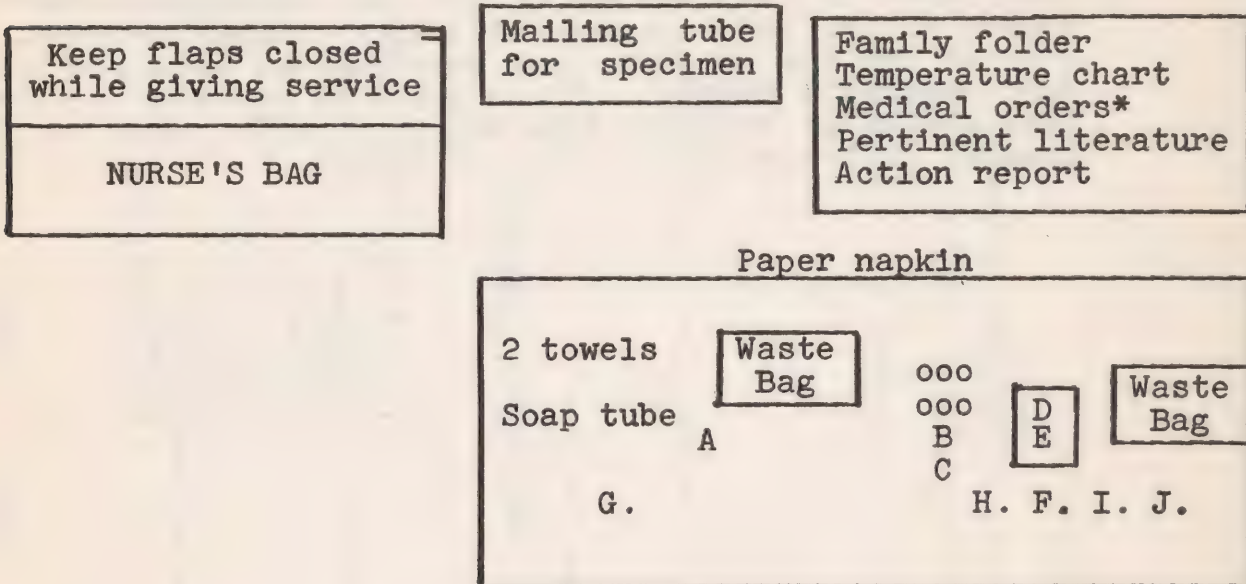
Nurse should carry in box in car extra supply of: towels, newspapers, and napkins

- h. Outer surface of bag should be cleaned and polished at regular intervals
(Bag dressing and saddle soap should be provided out of contingent funds for the nurse's convenience in keeping outer surface of the bag in good condition)
- i. Each nurse is responsible for the bag and contents assigned to her and is responsible for signing the check list of bag and contents upon assuming her position and upon leaving a county. (Glass supplies and worn equipment are to be replaced from county supplies when exhausted or broken in the line of duty)

2. Care of the sick - General nursing care

Nurse must be guided as to how elaborate a set-up she makes by the service she renders, i.e. if temperature, only unpack equipment needed for thermometer technique:

Single fold newspaper



- Hand washing facilities at bag for single set-up. Separate hand washing set-up in bathroom or washroom if desired
- 6 cotton balls 3 water, 2 green soap, 1 dry
- Thermometer - mouth or rectal as indicated. (See Suggested Thermometer Technique)
- Enamel basin with cover (when needed for dressing, urinalysis, sterilization)
- Urinalysis set in "d" (Give care and do urinalysis last) (See Technique)
- Tycos - use napkin protecting Tycos on patient's arm
- Clean napkin - after use of Tycos, place clean napkin around fan-folded cuff of Tycos (Gauge inside and bulb outside napkin)
Rubber band - place rubber band around napkin and rubber tubing)
- Tongue blade
- Sputum bottle

" 7-7-49

*Medical orders: Instruct patient to take and record T.P.R. 2xD. 8:00 a.m. and 8:00 p.m. for 7 days. N. to do routine urinalysis and B.P.; Instruct pt. to collect and send sputum spec. to State Lb. Pt. to Dr's. office 7-14-49.

(Signed) John Segora, M.D. "

- j. Complete family folder and family nursing record. (See Directive for Recording)
- k. Action report - completed and left in the home when physician is making home visits. Completed in home or office and mail to physician. (Physician may write orders on this form)
- l. Communicable disease set-up - to be made beside the nursing bag. A second set-up is to be made in the contaminated area of the patient. (See suggested Isolation Technique.)
 - a. Following care - all equipment, including thermometer is cleansed at the bedside in the regular manner, then carried back to the bag and cleansing repeated.

PART IV

SERVICES

- A. COMMUNICABLE DISEASE CONTROL
- B. VENEREAL DISEASE CONTROL
- C. TUBERCULOSIS CONTROL
- D. MATERNITY SERVICE
- E. CHILD HEALTH SERVICE
- F. SCHOOL HYGIENE SERVICE
- G. ADULT HYGIENE
- H. MORBIDITY SERVICE
- I. CRIPPLED CHILDREN SERVICE
- J. GENERAL SANITATION
- K. PROTECTION OF FOOD AND MILK
- L. LABORATORY

PART IV - SERVICES

A. COMMUNICABLE DISEASE CONTROL

1. NOPHN Suggested Functions in acute communicable disease control
 - a. Promoting the complete reporting of reportable diseases
 - b. Teaching the need of medical care and assisting the family to secure it
 - c. Giving or arranging for home nursing care, teaching through demonstration, and supervising care given by relatives and attendants
 - d. Assisting the family to carry out isolation technique and general and specific medical instructions
 - e. Interpreting health department procedure to individuals and groups
 - f. Assisting, under authority of the health department, in making epidemiological investigations
 - g. Instructing parents, teachers, and other individuals and groups
 - (1) To recognize early symptoms and isolate suspected cases
 - (2) To carry out proper precautions to prevent the spread of infection
 - (3) To provide adequate convalescent care
 - h. Helping to secure specific immunization

2. Home care of communicable disease

"A communicable disease shall mean and include any disease which may be transmitted directly or indirectly to other persons or animals. It shall embrace the terms infectious and contagious disease."*

- a. The most frequent sources of infectious and contagious diseases are in the
 - (1) Respiratory tract
Spread by secretions of the nose, throat, eyes and ears; they are probably transmitted directly by inhalation or ingestion of the moist warm pathogens. These diseases may also be spread indirectly by freshly contaminated articles
 - (2) Intestinal tract
Are often indirectly spread by transmitting the infectious agent to food or food containers by the patient's or carrier's fingers soiled with feces or urine; and also by flies. They are also spread by contaminated water supplies
- b. Nurse's responsibility in guiding the family to assume responsibility for control of ALL communicable diseases
 - (1) Report the disease or suspected disease to the county health department

*State of New Mexico Department of Public Health Regulations Governing the Control of Communicable Disease, p. 2 (c).

- (2) Separate the sick from the well
 - (a) See suggested Isolation Room Set-up. Isolation may be carried out in one room when the contaminated area is considered to extend 3-5 feet from the bed, and tissues are used to cover nose and mouth droplet infection
 - (3) Care of the sick
 - (a) Demonstrate care of the sick according to standing or specific orders
 - (b) Isolation to prevent cross infections and control complications (One attendant, who may be a member of the family, should be responsible for the care of the patient)
 - (4) Prevention of the spread of the disease to other members of the family
 - (a) Concurrent disinfection and ordinary cleanliness in the sick room
 - (b) Wash hands with soap and water BEFORE AND AFTER care is given the patient
 - (c) Dishes and linen washed in hot soapy water
 - 1) Rinsing dishes with hot (170°) water is the preferred precaution
 - (d) Only RESPONSIBLE ATTENDANT, adult if possible, permitted in patient's area or room
 - (e) Terminal disinfection when required
 - (5) Prevention of the spread of disease to other members of the community
 - (a) Isolation of the patient (See Isolation Room Set-up)
 - (b) Quarantine of contacts
 - 1) In specific diseases, follow the instructions required by State of New Mexico Department of Public Health Regulations Governing the Control of Communicable Disease, regarding individual and family
 - (c) Screening of house
 - (d) Sanitary facilities or control
 - (e) Terminal disinfection when required
 - (6) Nurse's responsibility in case load management
 - (a) If a nurse is caring for patients with communicable diseases, especially streptococcal infections, including scarlet fever and erysipelas, she should avoid carrying concurrently postpartal and surgical cases and patients with debilitating diseases. If it is necessary for her to carry both types of cases, the visits to streptococcal cases should be made last in the day. The greatest protection comes through the use of good technique in all visits
- c. Methods of disinfection and approved solutions
- (1) Boiling - place in cold water all articles that can be boiled and boil for 15 minutes
 - (2) Soap and hot water - use soap and hot water with friction on all articles. For articles that cannot be boiled

wash in hot water and soap with friction, follow by exposure to air and sunshine (e.g., floors, walls, furniture, etc.)

- (3) Chloride of lime - make a stock solution by adding 6 ounces (12 tablespoons) to a small amount of water making a paste, add water to paste to make 1 gallon. Place in corked bottle (brown if possible) and keep in a dark place

(a) To disinfect stools, vomitus, bath water and urine

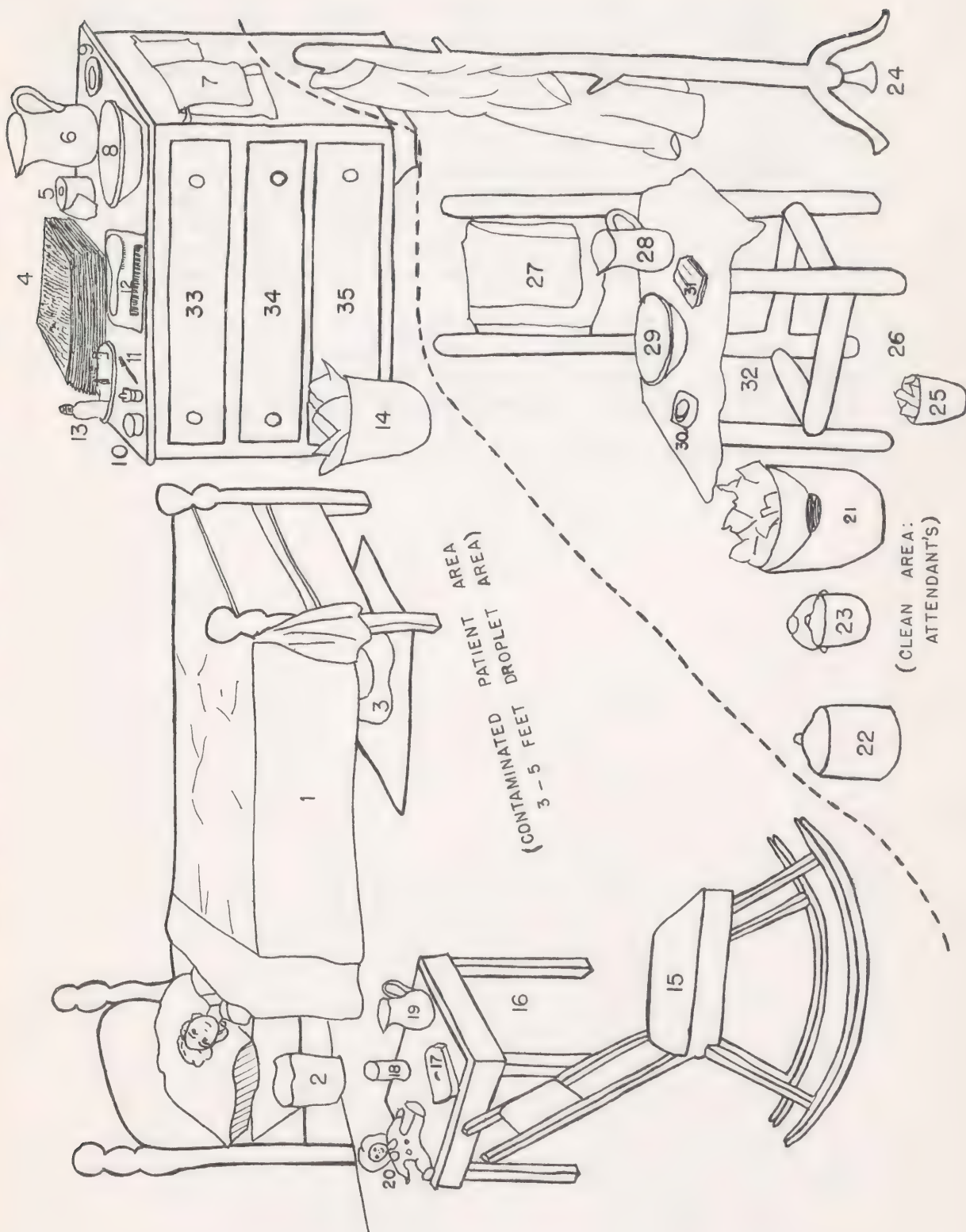
- 1) Add equal amount of solution to waste matter
- 2) Break up and mix thoroughly with a stick
- 3) Let stand 2 hours
- 4) Flush down toilet stool or bury
- 5) Rinse container and stick with solution; bury stick

- (4) Commercial chlorine solutions may be used

(a) Such as Chlorox and Purex, 5.25%; make a stock solution by adding 24 ounces ($1\frac{1}{2}$ pints or 48 tablespoons) and adding enough water to make a gallon of solution

- 1) Proceed as with chloride of lime stock solution

ISOLATION ROOM SET-UP



3. Isolation room set-up
(Windows and doors screened)

Numbered position
on the diagram

- 1 Bed
Separate bed in a separate room whenever possible, or separate bed in one-room house and contaminated area is considered to extend 3-5 feet from bed if tissue is used to cover mouth and nose droplet
- 2 Paper bag or folded newspaper bag pinned to bed
- 3 Bedpan between newspapers or in shopping bag
- 4 Newspapers
- 5 Toilet paper
- 6 Pitcher for clean bath water
- 7 Towels and washcloth
- 8 Wash basin
- 9 Soap in container
- 10 Emesis basin - shallow pan
- 11 Toothbrush and paste or powder
- 12 Comb and brush
- 13 Small tray for medicine (cardboard box cover); thermometer in dry covered container
- 14 Wastepaper basket for patient
- 15 Wooden rocker or chair
- 16 Bedside stand (box may be used)
- 17 Kleenex or soft tissues
- 18 Drinking glass
- 19 Pitcher for drinking water
- 20 Toy or materials for occupational therapy
- 21 Waste pail
- 22 Boiler for soiled linen
- 23 Kitchen kettle for soiled dishes
- 24 Attendant's gown - gown may be hung on hook near door, with contaminated side out
- 25 Wastepaper basket for attendant
- 26 Attendant's scrub area
- 27 Towels - paper towels preferred
- 28 Pitcher for water
- 29 Hand basin
- 30 Soap in container
- 31 Paper napkins and/or paper towels
- 32 Chair protected with newspapers (back and seat)
- 33 Patient's linen in drawer
- 34 Patient's clothing in drawer
- 35 Toys and occupational therapy or other personal belongings

Other articles needed: tray and dishes for food; cord to tie garbage and packages of waste wrapped in newspapers

4. Suggested isolation technique

a. General differentiation from procedure in non-communicable disease

- (1) Nurse's hat may be worn but coat and bag are placed 3-5 feet from patient's area or outside of patient's room
- (2) Equipment, etc., taken from bag to patient's room should be cleaned and disinfected, protected or destroyed after use
- (3) When family does not have a thermometer of its own, the one from the nurse's bag may be used, cleansed in the room according to suggested procedure, cleansed again at the bag set-up and returned to the bag at the end of the visit
- (4) All supplies should be assembled and the doctor's orders obtained before going to the patient's room or area so that the nurse can, if possible, remain in the patient's room or area until care is finished
- (5) Nurse's gown or paper apron is left in the patient's room or area with contaminated side exposed, or, folded with clean side out and placed in paper bag
- (6) Isolation technique to be adapted to specific disease of Communicable Disease Control Outline, Group I, II and III, in conformity with regulations

b. Suggested procedure

- (1) Organization for work
 - (a) Before entering the patient's room, prepare work area removing from the bag the following additional articles
 - 1) Gown or paper apron
 - 2) Extra paper towels, if needed
 - (b) Make extra large paper bag for nurse's gown (a shopping bag may be used) for storage in patient's room, or for transporting. Make other bags as needed
 - (c) Assemble supplies for use in sick room (see Isolation Room Set-up)
 - 1) Place on newspapers outside door (left there or placed in clean area)
 - a) Kitchen kettle for patient's dishes one-fourth full of cold water
 - b) Boiler for patient's soiled linen one-fourth full of soapy water
 - 2) Supplies for hand washing unit for room without running water (solution for hands is used only if ordered by physician)
 - a) Basin
 - b) Soap in dish
 - c) Pitcher of water
 - d) Towel
 - e) Pail for waste

- 3) Toilet tray and supplies
 - a) Toothbrush, paste, glass, receptacle for rinsing mouth
 - b) Comb and brush
 - c) Soap in dish
 - d) Toothpick swabs
 - e) Vaseline, oil or other lubricant
 - f) Any other articles necessary for patient's comfort
- 4) Large house apron or substitute which will completely cover attendant's dress (smock or dress opened in back makes a good substitute)
- 5) Supply of newspapers and paper bags for
 - a) Dry waste, e.g., uneaten food
 - b) Bag pinned at head of bed for used tissues
 - c) Protecting furniture
- 6) String and pair of scissors, for wrapping food and dry waste
- 7) Tissues for nose and mouth discharges
- 8) Bedpan, cover, and toilet tissue (newspaper or shopping bag make good bedpan covers)
- 9) Bath basin
- 10) Clean linen
- (d) Care of patient
 - 1) Put on gown
 - 2) Make clean surface for work area, protect furniture as necessary
 - 3) Arrange equipment for convenience, i.e.,
 - a) Empty dresser drawer for daily care equipment
 - b) Protected chair for hand washing unit near door
 - 4) Take pulse
 - 5) Take temperature, cleanse thermometer and leave it in a safe place in patient's room until care is finished
 - 6) Give treatments, such as enema, at this time, if ordered
 - 7) If disease is in Group III, disinfect feces and urine in bedpan or urinal (see Methods of Disinfection and Approved Solutions, A.c.p.29)
 - 8) Wash hands; soap and running water is used for each hand washing
 - 9) Bathe patient as in general care except in cases where pronounced rash is present in which case the nurse must obtain definite instructions from the physician; cleansing tissues or toilet paper should be used for nose and throat discharges and are deposited in paper bag pinned at head of bed
- (e) After-care of equipment
 - 1) Before removing gown
 - a) Scrape dishes, pack neatly and place in kitchen kettle of cold water

- b) Roll soiled linen in neat bundle, emesis basin on top
- c) For diseases in Group II or III, place linen in container of soapy water. Sputum basin may be boiled or soaked in with the linen
- d) Rinse out bath basin, dry and put away
- e) Rearrange and replace toilet tray
- f) Pin fresh paper bag to head of patient's bed
- g) Wrap dry waste securely in newspaper bundle or paper bag
- h) If disease is in Group III, following disinfection of solid waste, feces and fluid waste according to directions, put in stool and flush. If no bathroom in isolation, place in slop jar or covered pail on newspaper in clean area (to be flushed down common toilet or buried)
- i) Wash hands, remove gown, fold with contaminated side in and place in paper bag

2) After removing gown

- a) Instruct attendant
 - (1 Hand washing technique
 - (2 Care of gown
 - (a Hang near door, contaminated side out with opening away from patient
- b) Take dishes in kitchen kettle to kitchen and place directly on stove. Nurse will teach mother, if she has no helper, to wash her hands before adding cold water to cover dishes and turning on the gas
- c) If disease is in Group III feces and urine disinfected according to directions, flush down the toilet (if there is no bathroom, empty fluid waste in earth pit and cover, rinse slop jar or covered pail and return to clean area)
- d) Wash hands under running water
- e) Take thermometer to bag set-up. Cleanse according to suggested procedure
- f) Wrap package of dry waste in several layers of clean newspaper or put in clean paper bag and tie securely. If no place to burn, put in garbage pail
- g) Wash hands and forearms under running water
- h) Write record outside patient's room or area

c. Conclusion of visit

- (1) Same as in morbidity service except that Action Report is left outside contaminated area

d. Terminal care

- (1) See State of New Mexico Department of Public Health Regulations Governing the Control of Communicable Disease, and Outline for Communicable Disease Control

(2) *See page 41*

A. COMMUNICABLE DISEASE CONTROL 5. Outline for Control of Communicable Diseases

	<p>Group I</p> <p>Examples are —</p> <p>Whooping cough, measles, pneumonia</p> <p>Home isolation techniques of questionable value as disease is transmitted in the prodromal stage</p>	<p>Group II</p> <p>Examples are —</p> <p>Scarlet fever, diphtheria, tuberculosis</p> <p>Home isolation techniques important.</p> <p>Transmitted by respiratory tract</p>	<p>Group III</p> <p>Examples are —</p> <p>Typhoid, dysentery, tuberculosis of rectum or bowel, poliomyelitis (?)</p> <p>Home isolation techniques important.</p> <p>Transmitted by gastrointestinal tract</p>
<p>Duties of Health Officer</p>	<p>See State of New Mexico, Department of Public Health Regulations Governing the Control of Communicable Disease and Regulations Governing the Reporting of Notifiable Diseases and Accidents (Section 3, Chapter 39, Laws of 1937)</p>	<p>Same as Group I</p>	<p>Same as Group I</p>
<p>Responsibilities of the Public Health Nurse</p>	<ol style="list-style-type: none"> 1. Immediately upon receipt of a report of a communicable disease with written authorization of the local health officer, nurse may placard, isolate patient, and quarantine contacts complying with all requirements of (above) regulations 2. Instruct the family in the control of specific disease and care of the sick as in this outline and in accord with (above) regulations 3. Assist family to interpret and follow specific orders of physician 4. Report the disease (medical diagnosis) or suspected disease to the county health department on three card forms (See Sample Forms) 5. Cooperate in the promotion of general sanitary improvements for community protection, e. g. screening, fly control, safe water and milk supplies 6. Promote and cooperate in immunization programs in accord with health officer's standing orders—State Department of Public Health, Diphtheria Immunization Law, Chapter 50, Session Laws 1943—State Department of Public Health, Vaccination Law, Provision for Vaccination (Section 14, Chapter 39, S. L. 1937, Sub-section 7) 	<p>Same as Group I</p>	<p>Same as Group I</p>

CONCURRENT DISINFECTION

Nursing Techniques By Groups			
Room	Private room, or isolate area 3 to 5 feet around patient's bed	Same as Group I	Same as Group I
Attendant	One responsible adult	Same as Group I	Same as Group I
Supplies for Care of Patient	Assemble all necessary equipment before entering contaminated patient area	Same as Group I—In addition keep all articles used by patient in his contaminated area	Same as Group I and II
Apron	Attendant to wear a large coverall apron at all times while giving care to the patient. Hang apron in clean area of isolation unit with contaminated side out	Same as Group I	Same as Group I
Handwashing	Wash hands and arms with friction in warm running water and soap before giving care after touching the patient or articles used by the patient, before touching anyone or anything outside contaminated patient area	Same as Group I	Same as Group I
Dishes	Wash in hot soapy water, Rinse with boiling water	Separate utensils recommended. Keep covered containers (with lid) $\frac{1}{4}$ full of cold water on newspaper outside contaminated patient area. Scrape unused food on extra thick newspaper and place dishes in container. The discarded food in newspaper and burn before last handwashing. Remove gown. Place dish container directly on stove. Wash hands. Light fire. Cover dishes with water. Boil dishes 15 minutes and wash as in Group I. When emptied, replace covered container $\frac{1}{4}$ full of water on paper outside contaminated patient area. If separate utensils are kept in contaminated patient area, disregard above. Wash as in Group I in contaminated patient area	Same as Group II

	Group I Wash in hot soapy water as regular laundry	Group II Keep covered wash boiler, tub, or large pail $\frac{1}{4}$ full of soapy water on newspaper outside contaminated patient area. Place soiled linen directly in boiler to soak. When ready to wash, set covered boiler directly on stove. Bring to a boil and boil for 15 minutes. Wash as regular wash. Replace covered wash boiler, $\frac{1}{4}$ full soapy water outside contaminated patient area	Group III Same as Group II
Body Discharges of 1. Ear 2. Nose 3. Throat 4. Gastro-intestinal tract (emesis) 5. Bladder 6. Bowel 7. Skin	Instruct patient to cover mouth and nose with tissue or clean cloth when necessary to sneeze or cough. Patient to place soiled tissue or cloth immediately into paper bag pinned to bed. Attendant to burn bag and contents daily or more often if necessary	Same as Group I	Before throwing emesis, urine, or stool into a toilet stool, or burying, follow methods of disinfection and approved solutions as outlined on p. 29
Milk and Milk Products		Notify dairy that they are not to pick up containers until authorized by the health officer. When possible paper containers are to be used for dairy products	Same as Group II
Money	May leave house when not handled by the patient	Same as Group I	Same as Group I
Mail		Consult postmaster regarding U.S.P.O. regulations	Same as Group II
Cleaning Supplies	Keep damp dust cloth, sweeper, mop, etc. in contaminated patient area	Same as Group I	Same as Group I

TERMINAL DISINFECTION

Nursing Techniques For All Groups	For specific disease, follow the State of New Mexico Department of Public Health Regulations Governing the Control of Communicable Disease
Patient	Bathe, dress in clean clothes. Remove from contaminated patient area
Room or Patient's Area Contents	Thoroughly cleanse with soap and hot water. Sun and air for 8 hours. If room has been badly contaminated by a careless patient, it is often necessary to remove paper and burn. Replace paper or paint.
Mattress, Pillows, Blankets, and Quilts	Expose to direct sun on each side for 8 hours. Burn badly soiled items
Newspapers and magazines which have been handled by the Patient	Burn
Books	Remove from patient at onset of disease. Sun for 3 days. Keep out of circulation for 2 to 4 weeks. In cases of anthrax or smallpox, burn
Cleaning Supplies	Wash in hot water and soap. Dry in sun

B. VENEREAL DISEASE CONTROL

1. NOPHN suggested functions in venereal disease control

- a. Assisting in finding cases and contacts and in securing medical examination and supervision
- b. Promoting continuity of treatment by helping the patient follow medical directions, and cooperating with other workers to this end
- c. Teaching patient and family the precautions to be taken to prevent the spread of infection
- d. Teaching scientific facts concerning these diseases to individuals and groups
- e. Giving or arranging for necessary nursing care, teaching through demonstration, and supervising care given by relatives and non-nurse helpers
- f. Assisting, under authority of the health department, in making epidemiological investigations
- g. Promoting the reporting of cases

- (2) If concurrent disinfection has been carefully practiced, terminal disinfection is simplified. All articles grossly contaminated should be boiled if possible or thoroughly sunned and aired not less than eight hours. Boil linen for fifteen minutes and dishes for fifteen minutes. The nurse should be familiar with and assist the family in carrying out these instructions

Should be on page 36.

VENEREAL DISEASE CONTROL MANUAL FOR NURSES

Prepared by

Frances S. Buck, R. N.
Assistant Public Health Nursing Consultant
Venereal Disease Division

FEDERAL SECURITY AGENCY
Public Health Service
1948

CONTENTS

I. Public Health Objectives.....	1
II. Program	1
III. The Venereal Disease Clinic.....	2
IV. The Public Health Nurse in the Venereal Disease Program..	9
V. The Educational Interview.....	11
VI. Contact Investigation.....	13
VII. Laws and Regulations.....	14
VIII. Records and Reports.....	14

VENEREAL DISEASE CONTROL

The venereal diseases include syphilis, gonorrhea, chancroid, granuloma inguinale and lymphogranuloma venereum. Syphilis and gonorrhea are the most prevalent and constitute the major public health problem in venereal disease control. Present methods of treatment for these diseases have brought about a change of emphasis in certain aspects in the control program. Attention is centered on casefinding and health teaching.

I. Public Health Objectives

- A. To control the venereal diseases, especially syphilis, through the early discovery of as many persons as possible who are infectious and to assist such persons to secure immediate and adequate treatment for the attainment of cure and the prevention of spread, through:
 - 1. The dissemination of information about the venereal diseases to the general community so that persons who suspect they may have acquired syphilis or gonorrhea will voluntarily seek medical care.
 - 2. The education of the patient infected with syphilis or gonorrhea to the need for prompt treatment and for epidemiological activities.
 - 3. The provision of adequate diagnostic and treatment services.
- B. To protect the health of every individual through the promotion of community responsibility in the prevention of the venereal diseases, through:
 - 1. The development of community facilities which will tend to maintain and promote well adjusted individuals and wholesome family and community life.
 - 2. The promotion of those factors--housing and employment--which will tend to raise the standard of living.

II. Program

The program should be based upon the needs and problems of the area. Although venereal disease control is recognized as a function of health departments, all other community resources should be utilized in developing a complete community program. An adequate program would include:

A. Activities

- 1. Casefinding through:
 - a. Referrals from health agencies, private physicians and other sources.
 - b. Premarital and prenatal examinations.
 - c. Surveys--industrial, tuberculosis control, mass blood testing, etc.

- d. Promotion of periodic health examinations
- e. Awareness of venereal disease in other phases of the health department program
- f. Interviewing venereal disease clinic patients
- g. Follow-up of sexual contacts of infectious syphilis patients
- h. Education of the public as to symptoms and prompt medical care
- 2. Health education through:
 - a. Talks to groups
 - b. Visual aids
 - (1) Educational material
 - (a) Films, slides, pamphlets and posters
 - c. Radio
 - d. Educational campaigns under the auspices of special community groups
- 3. Diagnosis and treatment through:
 - a. Venereal disease clinics
 - b. Utilization of rapid treatment facilities
 - c. Referral to other sources

B. Facilities

- 1. Rapid treatment centers and bed contracts
- 2. Venereal disease clinics
- 3. Hospitals
- 4. Private physicians
- 5. Other clinics

It is essential to know the functions of each as well as the policies and procedures. Knowledge of hours, location and available transportation is also necessary. Working relationships should be established

III. The Venereal Disease Clinic

The clinic may be set up as a regular venereal disease clinic or as part of a general clinic. The latter is preferable but may not be possible in all areas.

A. Organization

- 1. Located in an accessible place of maximum convenience to the area to be served
- 2. Hours arranged to suit the needs of the patient group as far as possible
- 3. Adequate number of clinic rooms

B. Management

The patient's first impression of the clinic molds his future behavior. Every effort should be directed toward making clinic visits a pleasant and educational experience.

- 1. All clinic rooms should be orderly, clean, well-lighted, well ventilated, and arranged for as great privacy as possible. Consideration of the location of treatment is necessary for a smooth flow of patients. Avoid "bottlenecks."

2. The waiting room should be attractive and large enough to accommodate the patient load, with adequate seating facilities
3. The physician and the interviewing nurse should each have complete privacy in which to interview patients
4. Patients should be seen in the order in which they appear at the clinic but with consideration given to pregnant women, mothers with children and working people

C. Personnel

The physical characteristics of the clinic are extremely important but even the most perfectly set-up clinic will fail if the personnel is inadequate in numbers, training and experience, and lacking in friendliness and sincere interest in the patient. For instance the personnel needed will be determined by the clinic activities. If, in addition to diagnosis and casefinding, treatments are to be administered by nurses both public health and clinic nurses will be required.

All personnel should have a real interest in the control of venereal diseases. They need to consider the patient as an individual. Courtesy and humaneness are essential. A businesslike attitude should prevail. Avoid discussion of a patient's condition or irrelevant conversation in the presence of patients. Harmonious working relations should exist. An understanding of medical instructions and procedures are necessary for uniformity and advice to patients.

1. Suggested minimum number:

- a. Physician
- b. Clinic Nurse
- c. Interviewing Nurse
- d. Clerk

2. Duties:

a. Clinic Nurse:

- (1) Prepares treatment and examination rooms and equipment for use
- (2) Participates in the physical examinations and diagnostic procedures
- (3) May give treatments under medical supervision
- (4) Supervises general conduct of the clinic
- (5) Sees that records are kept in an accurate and complete manner
- (6) Supervises the work of the clerk

b. Clerk:

- (1) Keeps laboratory reports copied on the records
- (2) Registers patients at clinic sessions
- (3) Acts as receptionist
- (4) Sees that records reach the various clinic stations

- (5) Sees that referral forms are properly filled out in patients for rapid treatment facilities
- (6) Makes out laboratory forms
- (7) Makes out case (morbidity) report forms
- (8) Executes any other reports or records
- (9) Files and maintains records in an orderly manner
- (10) Performs other stenographic duties
- c. Public Health Nurse
 - (1) Interviews patients at the clinic for case-finding and education of the patient
 - (2) Maintains working relationships with other agencies
 - (3) Refers patients to other agencies as the need indicates
 - (4) Acts as liaison between the clinic and the public health nursing staff

D. Quarters and Equipment:

Well equipped and attractively furnished clinic rooms should be provided and kept clean. Drinking water and adequate toilet facilities should be accessible. Examination and treatment rooms should be carefully set up with all necessary equipment to facilitate services to patients and avoid confusion. Dressing cubicles should be provided in or near the examination rooms. Adequate storage space or facilities for supplies should be provided. Equipment should be in excellent condition at all times---good syringes and sharp needles. Emergency tray should be kept in readiness

1. Waiting room

- a. Chairs arranged conveniently
- b. Reading material
 - (1) Kept fairly up to date and in good condition
 - (2) Selected--within the intellectual capacity of patients
 - (a) Current magazines
 - (b) General health pamphlets
- c. Posters--attractive and of a general health nature, changed frequently

2. Clerk's area

Located in waiting room so that the flow of patients to the various clinic rooms may be directed

- a. Desk and two chairs
- b. Files of patients' records
- c. All material that may be used
 - (1) Necessary record forms
 - (2) Stationery
 - (3) Scratch pads
 - (4) Pen, ink, blotter

3. Examination room

- a. Desk and chairs
- b. Desk light, if needed
- c. Writing materials
- d. Literature on syphilis, gonorrhea, and the rapid treatment center
- e. Equipment table with the following articles:
 - (1) Sphygmomanometer
 - (2) Percussion hammer
 - (3) Flash light
 - (4) Stethoscope
 - (5) Tongue depressors
 - (6) Cotton applicators
 - (7) Dry cotton pledgets
 - (8) Alcohol pledgets
 - (9) Alcohol } in covered jars
- (10) Thermometers, mouth and rectal (on separate tray set-ups)
- (11) Sponge forceps
- (12) Rubber gloves
- (13) Tube of lubricant
- (14) Vaginal speculae--3 sizes, large, medium, and small--kept covered
- (15) Bowl of soapy solution for used speculae and gloves
- (16) Outfits for taking darkfield specimens
- f. Other supplies:
 - (1) Hand brush
 - (2) Soap
 - (3) Paper towels
 - (4) Receptacle for waste, paper lined
 - (5) Doctor's coat
 - (6) Gooseneck floor lamp with daylight bulb
 - (7) Scales
 - (8) Paper tissues
 - (9) Drape sheets } for examining table
- g. Spinal tray:
 - (1) Towels
 - (2) Iodine, $3\frac{1}{2}$ - 5%
 - (3) Novocain, if used
 - (4) Cotton applicators
 - (5) Alcohol pledgets
 - (6) Cotton pledgets } in covered jars
- (7) Sterile specimen tubes and laboratory forms
- (8) Lumbar puncture needles, 21 x 3
- (9) 2 cc. syringes
- (10) Hypodermic needles, 25 x 5/8
- (11) Dressings and adhesive tape or commercially prepared covering
- (12) Scissors
- (13) Rubber bands

- h. Examination table with pillow
 - i. Revolving stool
 - j. Foot stool
 - 4. Treatment rooms
- Provision should be made for separate intravenous and intramuscular treatment arrangements. A single room may be divided into cubicles or spaces. Sink with hot and cold running water necessary. Work space provided in intravenous room

Intravenous room:

- a. Gooseneck lamp with daylight bulb
- b. Sterilizer
- c. Syringe forceps
- d. Jar of antiseptic solution for forceps
- e. Revolving stools for patient and technician at treatment table
- f. Apron for nurse
- g. Table for intravenous treatments, with following:
 - (1) Towel or clean cover on which to place supplies
 - (2) Sterile syringes, 10 cc., between sterile towels, in sterile pan or on segmented blocks
 - (3) Sterile needles, $1\frac{1}{2}$ " 22-23 gauge, in sterile Petri dish or between sterile towels
 - (4) Sterile thumb forceps or hemostat for handling needles
 - (5) Petri dishes for covering drug solutions
 - (6) Sterile medicine glasses or beakers for mixing drugs
 - (7) Paper towel under mixed drugs, marked with drug and dosage
 - (8) Sterile graduate (100 cc.)
 - (9) Enamel tray with small amount of cold water for soiled syringes and needles
 - (10) Jar with cotton pledgets wet with alcohol
 - (11) Tourniquet
 - (12) Support for arm (small sand bag) covered by clean paper towel or napkin for each patient
 - (13) Sterile distilled water
 - (14) Drugs
 - (15) Shallow receptacle containing alcohol for metal files and ampules of drug
 - (16) STS equipment - laboratory forms, rubber bands
- h. Waste container, paper lined
- i. Emergency tray
 - (1) Adrenalin or epinephrine ampules
 - (2) Sterile 2 cc. syringes and $5/8$ " needles, 25 gauge
 - (3) Aromatic spirits of ammonia
 - (4) Drinking cups

Intramuscular Room:

- a. Small table with:
 - (1) Alcohol pledgets in jar
 - (2) Bismuth
 - (3) Penicillin
 - (4) Sterile syringes, 2-5, 10 cc.
 - (5) Sterile needles, 22-22 gauge, 2 to 3" length (in sterile Petri dish covered)
 - (6) Container with carbon tetrachloride or other solvent for soiled needles
- b. Low table with pad on which the patient can lie for treatment (6' x 20" x 20" suggested)
- c. Paper tissues for hip treatment table
- d. Waste container, paper lined
5. Interviewing nurse's room
 - a. Desk and 2 comfortable straight chairs
 - b. Appropriate literature and other visual aids
 - c. Directory of clinics Supplement No. 4 to JVDI
 - d. List of rapid treatment facilities, April 1947, JVDI
 - e. Writing materials
 - f. Necessary forms

E. Procedures

1. Care and preparation of equipment:
 - a. Barrels and plungers of syringes should be separated when boiled. Keep together with a rubber band
 - b. Needles should be kept sharp and in good condition
 - c. Boil syringes, needles, and glassware for 10 minutes
 - d. Handle sterile syringes, needles, and glassware with sterile forceps
 - e. All glassware, syringes and needles used for arsenicals should be cool before using
 - f. Rinse syringes and needles after use under cold running water when used for venipuncture and arsenical preparation. Those used for bismuth and POB with acetone or carbon tetrachloride, wash with soapy water and rinse thoroughly before boiling
 - g. The trocar and cannula or lumbar puncture needles should fit perfectly. There should be no rough edges. After use, wash well under cold running water, test for plugging. Boil, then dry thoroughly. Replace cannula, put away unsterile
2. Spinal puncture
 - a. Explain the nature of the procedure to the patient and how he can cooperate to make the test easier
 - b. The patient removes clothing down to the waistline and a sheet or cape is draped about him leaving the back exposed
 - c. Prepare syringe with novocain, if used
 - d. Place patient astride a straight chair, arms folded on back of chair, and lay head on arms and bow out back; or

- e. Place patient on examination table on right side. Assist him in the proper position--head bent forward and knees brought up to chest so that the back bows outward with shoulders and hips in a vertical plane
 - f. Paint the site of the intended puncture with iodine then swab area with alcohol pledget
 - g. Instruct patient to remain still
 - h. Assist physician in collection of spinal fluid specimen
 - i. Place stopper securely into the specimen tube as soon as the physician removes the needle. Label properly
 - j. Cover puncture site with dressing held by adhesive plaster
3. Blood specimens:
- a. Use a sterile dry syringe, needle and specimen tube
 - b. Avoid contamination of specimen
 - c. When the amount of blood required (5-10 cc.) is drawn, remove tourniquet slowly and withdraw needle quickly
 - d. Apply pressure to puncture area with alcohol pledget for a few minutes. (Patient can hold this)
 - e. Remove needle from syringe and expel blood gently into specimen tube and place stopper securely in tube
 - f. Insure proper labeling to avoid confusing specimen with that of another patient
 - g. Allow to stand 30 minutes at room temperature
 - h. Put in a safe cool place until it can be taken or sent to the laboratory
4. Injection therapy:
- The nurse should not administer injection therapy unless she has had special training in the proper technique and a physician is present. It is easier for patient if hip injections are administered with patient lying face down on a low treatment table
- a. Bismuth
 - Should be mixed thoroughly by shaking the bottle (Bottle may be warmed by placing on top of sterilizer.) Draw only one dose in the syringe at a time.
 - (1) Cleanse site of injection (upper, outer quadrant of the buttock) with alcohol pledget
 - (2) Aspirate after the needle has been plunged into the muscle to avoid injection in the blood stream

- (3) Before withdrawing needle, detach syringe from the needle and draw up plunger to about $\frac{1}{2}$ cc. mark. Attach needle and push down plunger to clear needle of bismuth
 - (4) Withdraw needle with smooth, swift stroke. Place alcohol pledget over site of injection and massage the area vigorously with a rotary motion for a few minutes
- b. Penicillin - Aqueous
- (1) Prepared according to directions accompanying the drug or by method prescribed by physician
 - (2) Cleanse site of injection with alcohol pledget
 - (3) Give intramuscularly
- Penicillin in oil and beeswax (POB)
- (1) Use 20-gauge needle and Luer-lock syringe. Needle and syringe should be dry; syringe may be warm
 - (2) Bottle of drug placed in warm water to facilitate withdrawal into the syringe and easier administration. Do not overheat
 - (3) Vials can be kept at room temperature
 - (4) Keep needle and tip of syringe empty of POB (a 16 or 18 gauge needle can be used for withdrawing POB into syringe)
 - (5) Give under aseptic technique
- c. Arsenical
- Wipe off ampules of drugs with alcohol pledget or put in alcohol bath. Examine ampules carefully before using, for cracks and change in color of drug. In mixing arsenicals use sterile distilled water at room temperature. Do not prepare more drug than will be used. If necessary to mix more use clean, sterile beaker or rinse used one thoroughly with sterile distilled water
- (1) Patient is seated at the table facing the technician with arm extended--elbow resting on a firm pad or sand bag
 - (2) Apply tourniquet
 - (3) Cleanse site of injection with alcohol pledget
 - (4) Administer treatment according to drug used
 - (5) As needle is withdrawn, an alcohol pledget is placed over the site of puncture
 - (6) The patient is instructed to bend arm at the elbow and hold pledget in place for a few minutes

IV. The Public Health Nurse in the Venereal Disease Program

The nurse carrying a generalized public health nursing service can integrate the venereal disease control program in her family health service. Many opportunities exist for correlating this program with other health services. An important phase is guidance to parents in the broader fields of sex education

A. Prerequisites

1. A knowledge of the medical aspects of these diseases
2. A broad understanding of social forces and of human behavior. In addition every public health nurse should possess the following qualifications:
 - a. The ability to approach patients with understanding
 - b. Genuine interest in the patient and his problems
 - c. A knowledge of the principles of teaching
 - d. An ability to develop satisfactory working relationships with community agencies

B. Functions

1. Casefinding, through:
 - a. Recognition of signs and symptoms of venereal disease in whatever public health nursing service she may be engaged
 - b. Awareness of pertinent facts in history taking which might be indicative of venereal disease infection
 - c. Encouragement of all pregnant women to have a serologic test and cervical smear in conjunction with a complete physical examination, early in pregnancy
 - d. Careful interviewing of diagnosed cases of infectious syphilis for contact investigation
 - e. Follow-up of sexual contacts elicited from known infectious syphilis patients to secure medical examination and treatment if indicated
 - f. Securing medical examination of members of the household who are considered contacts
2. Health teaching
 - a. To persons infected with venereal disease and those suspected of having a venereal disease, to interpret:
 - (1) the specific aspects of infection
 - (2) the need for treatment
 - (3) the part patients may play in the control of venereal diseases by being enlightened persons
 - b. To the general public:
 - (1) To give information to persons relative to the venereal diseases, prevalence and treatment facilities
 - (2) To teach the importance of periodic and complete medical examination including blood tests
 - (3) To stimulate interest in the venereal diseases so that they may understand the problems and needs, thus motivating them to participate in the control program
 - (4) To assist parents in the guidance of young children in family life education

V. The Educational Interview

A. Purposes

1. To inform the patient concerning his disease and the need for treatment
2. To assist the patient with treatment plans
3. To assist the patient to recognize and acknowledge any personal problems which may interfere with treatment plans and assist him in solving these problems if necessary
4. To discover other health and social problems of the patient and assist him in obtaining a satisfactory solution
5. To motivate the patient to practice hygienic living
6. To encourage the patient to reveal the names of all sexual contacts for casefinding purposes and the prevention of spread
7. To stimulate the patient to be a lay worker in the venereal disease control program

B. Type of cases to be interviewed in order of priority:

1. Persons diagnosed as having primary and secondary syphilis
2. Pregnant women with syphilis
3. Others as time permits

C. Procedure

1. Provide privacy--no interruptions during interview
2. Obtain all the data possible from the medical record--social history, diagnosis and physician's recommendations--before seeing patient
3. Invite patient into nurse's office. Begin by introducing yourself and making some simple statement of the reason for the interview. Make it clear that the interview is the usual procedure
4. Establish confidence with the patient and put him at ease
5. Find out what he understands about his disease and treatment recommendations. Begin the interview at the point of interest of the patient. Encourage the patient to talk but guide the conversation around to the discussion of his disease as soon as possible
6. Indicate by brief relevant comments or questions that you have grasped the essential points of the patient's story
7. Listen and anticipate his problems
8. Accept the patient on his own basis. Note his reactions and attitudes
9. Maintain a sympathetic and courteous manner. Sincerity and frankness are extremely important

10. During the first interview, go only as far as the patient can go. See him again on his next visit if necessary
11. Use visual aids, if possible, in explaining the disease

D. Content of Interview

This depends on the patient, his particular needs, and abilities. In most instances, the following items should be included:

1. Discussion of the disease (guided by the stage of the disease, mode of infection, marital status, employment, etc.)
 - a. Nature of the disease
Symptoms and stage
 - b. Treatment and plan. (If eligible for rapid treatment explain procedure.) When patients are treated for gonorrhea only, they should be informed of the possibility of exposure to syphilis at the time that gonorrhea was acquired, the need for frequent STS over a long enough period of time to rule out syphilis. They should also be instructed as to symptoms and necessity for immediate medical examination if any appear
 - c. General discussion of how the disease is spread. What the individual may do to prevent spread. Public health responsibility of the clinic and health department
 - d. Infectious precautions--stress abstinence from sexual intercourse until adequately treated
2. Discussion relative to contacts
Sexual contacts of infectious syphilis our main concern
Explain:
 - a. Reasons we are interested in contacts
 - b. Methods of follow-up prior to asking names and addresses

E. Procedure for obtaining contact information

1. Patient should be questioned only after he understands thoroughly what his infection is and has full confidence in the nurse
2. Patient should be made to feel he has an excellent reason for giving this information
3. Stress that the information is confidential and his name will not be divulged
4. If complete name and address cannot be secured, obtain as much identifying information as possible
5. It is important to write names, addresses and identifying data as quickly and correctly as possible as the information is secured
6. Keep in mind relative periods for contact investigation
Try to figure from some holiday or special event for this

- period, as it will assist the patient to recall all the contacts during infectious period more readily
7. When feasible, the patient should be urged to accept responsibility for securing the medical examination of his contacts, especially the marital partner. The nurse may need to assist the patient in formulating plans for this

VI. Contact Investigation

A. Purpose

1. To interpret the possibility of exposure to syphilis
2. To give information about the disease to which the contact may have been exposed
3. To urge prompt medical examination and treatment, if indicated

B. Types of contacts to be followed

1. Contacts of primary and secondary syphilis cases--urgent follow-up within 24 hours
2. Infants of female syphilitics
3. Contacts of early latent syphilis cases
4. Contacts of other venereal disease as indicated and as time permits

C. Procedure

1. Be familiar with all available information relative to the contact (social data and the disease to which exposed) before making the visit
2. See the contact personally if possible. In the event that it is difficult to do this, arrange an appointment at the nurse's office by telephone or letter. (If by letter, use care in content, should it be opened by another person. Conversation by telephone should be guarded.)
3. Avoid giving any information or becoming involved in conversation with any other person relative to the purpose of the visit
4. Obtain privacy for the interview
5. Introduce self and state simply the purpose of the visit in a manner to indicate sincere interest in the person's welfare. Explain that there is information which would indicate the person has been exposed to a serious communicable disease (syphilis or gonorrhea) and it was felt he would appreciate knowing it
6. Under no circumstances should the identity of the informer be revealed to the contact. If the contact insists on knowing, state that all information received by the health department is confidential and cannot be revealed

7. Be tolerant of contact's reactions and attitudes but attempt to interpret the need for medical examination
8. Utilize the visit as an educational opportunity to give the person information about the disease to which exposed
9. Determine from the contact his plan for medical examination. Secure the name of the private physician or clinic and when he plans to visit. It is advantageous to notify the physician or clinic in advance of the contact's contemplated visit to explain the purpose of his visit and arrange for securing a report later

Lay investigators may also be utilized in follow-up activities. If so, policies should be outlined in advance. Cases with other health problems or in a family already being carried by a public health nurse should be referred to her

VII. Laws and Regulations

It is important to be familiar with public health laws and regulations governing reporting and treating of infected persons. These include:

- A. Reporting cases
- B. Premarital and prenatal laws
- C. Control of gonorrheal ophthalmia neonatorum

Quarantine should be used only after all persuasive attempts have failed. Consider whether the patient understands what disease he has, and the need for treatment for protection of himself and of others; the facilities available and how he can make use of these and if there are obstacles which may prevent his accepting or securing treatment. Injudicious use of legal and quarantine measures often defeat the venereal disease control program by frightening patients or potential patients away from diagnosis and treatment sources. Public Health Nurses should not be utilized in enforcing legal measures.

VIII. Records and Reports

A. Purpose

1. To assist the clinic and health department to render a better quality of service to the individual
2. To make available information concerning prevalence of venereal disease
3. To assist in providing diagnostic and treatment facilities
4. To provide a means for evaluation of the program
5. To interpret the work to the public and other interested agencies

B. Type - Each State usually develops its own records.

The ones most commonly used are:

1. Medical record of patient. (history, physical findings, diagnosis and treatment)
2. Master file card. (register of all diagnosed and suspected cases)
3. Case (morbidity) report forms
4. Epidemiological report forms
5. Venereal disease control activity report (prepared for the U. S. Public Health Service quarterly)

Records and reports are of very little value unless the information on them is complete and accurate.

Adequate file cabinets are necessary for filing records properly. Because of the confidential nature of patients' records, the file should be kept in a safe place but accessible to health department personnel

Pages 16-41 missing

C. TUBERCULOSIS CONTROL

1. NOPHN suggested functions in tuberculosis control

- a. Assisting in securing reporting of all cases
- b. Assisting in finding cases, especially those with early minimal lesions and their contacts, and securing medical examination and supervision
- c. Securing medical examination and supervision for all cases and contacts
- d. Assisting, under authority of the health department, in making epidemiological studies, and where feasible, in installing central case registries
- e. Helping to arrange for sanatorium and post-sanatorium care
- f. Giving or arranging for necessary nursing care, teaching through demonstration, and supervising care given by relatives and attendants where sanatorium care is not available or is refused by the patient
- g. Using state and local facilities for rehabilitation of the patient
- h. Teaching patient and family the importance of personal hygiene and the precautions to be taken to prevent the spread of infection
- i. Stressing the importance of early diagnosis and x-ray examination
- j. Interpreting the significance of the tuberculin test
- k. Helping patient and family with emotional and social adjustment to a long-term communicable disease
- l. Helping to inform the community regarding prevention, control, and treatment of tuberculosis
- m. Assisting in integrating services of clinics, sanatoria, private physicians, health department, and other related health and social agencies

2. State of New Mexico laws relating to tuberculosis

Refer to Regulations Governing Control of Communicable Disease

3. Tuberculosis control division

Under the general direction of a full time medical director the following field staff serves in the Tuberculosis Control Division

- a. Nursing consultant
Assists with community education, x-ray surveys, staff education for nurses and is available for consultation regarding the tuberculosis nursing program
- b. Case records analyst
Establishes case registers and assists local personnel in maintaining their registers
- c. Project administrator
Precedes photofluorographic units in counties and assists local communities in organization work necessary for surveys

d. Technicians and assistants

One photofluorographic operator and one assistant is employed for each of the two photofluorographic units

4. Case finding

a. Mass x-ray surveys

Two 70 mm. photofluorographic units are used. One is a mobile and one a portable unit. They are in continuous use throughout each of the ten health districts

b. Home nursing visits

Nurses should be on the alert for patients showing suspicious symptoms on all home and clinic visits in the total nursing program

c. Reports from private physicians

These include communicable disease reports and sputum reports from the Public Health Laboratory

d. Household contacts of known cases

e. Check death certificates for tuberculosis deaths, and if contacts were not followed previously, do follow-up work

5. Medical care

a. State Tuberculosis Sanatorium, Socorro, N.M.

This is under the administration of the Department of Public Welfare. Nurses may get information from local department of Public Welfare offices regarding regulations for hospital admission. Hospital admission and discharge reports are routinely sent to county health departments by the State Department of Public Welfare

b. Private sanatoria

Methodist Sanatorium, Albuquerque, N.M.

A semi-private sanatorium for all stages of pulmonary tuberculosis

St. Joseph Sanatorium and Hospital, Albuquerque, N.M.

A semi-private sanatorium for all stages of pulmonary tuberculosis. In connection, there is a hospital to which other forms of tuberculosis and other types of chest diseases are admitted. Children admitted, Negroes admitted

Southwestern Presbyterian Hospital, 1012 E. Gold Avenue, Albuquerque, N.M.

A semi-private general hospital with special provision for tuberculosis in any form. Negroes admitted in private rooms

Valmora Sanatorium, Valmora, N. M.

For all stages and forms of tuberculosis. Children admitted in separate buildings. Capacity 75 (65 adults and 10 children) Out-patient service available for pneumothorax refills

St. Vincent's Hospital, Santa Fe, N.M.

Capacity for tuberculosis cases, two to three beds.

Diagnostic and treatment facilities

c. Clinics

The Tuberculosis Control Division encourages, and has a limited amount of equipment available to assist in establishing chest clinics in the state

d. Federal institutions

(1) Veterans' Hospitals

Ft. Bayard, N.M.

Albuquerque, N.M.

Medical social workers make home visits to patients throughout the state

(2) U. S. Marine Hospital, Ft. Stanton, N. M.

(3) Albuquerque Indian Sanatorium

e. State Public Health Laboratory

6. Department of Public Welfare

The Department of Public Welfare budgets for 100 per cent of needs of tuberculosis families under their care. Public health nurses may contact the County Department of Public Welfare regarding cases.

Food budgets are increased upon recommendation of the private physician, or the public health nurse. Dietary problems should be discussed with the patients by the public health nurse rather than by case workers. A mimeographed sheet, "Food for the Tuberculosis Patient," is available in Spanish and English and may be ordered from the State Department of Public Health

7. Supplies available for educational programs

a. New Mexico Tuberculosis Association, P.O. Box 1665, Santa Fe, N. M., supplies leaflets on tuberculosis. Samples of available literature will be sent on request

b. Tuberculosis Control Division, New Mexico State Department of Public Health, Box 711, Santa Fe, N. M.
Film library list

8. Follow-up contacts

The following chart is a guide to the nurse for frequency in examination of contacts

Age	Tuberculin Test	X - ray
18 years or over	No	X-ray on discovery. Repeat every 6 months during contact. When contact is broken, x-ray in 6 months. If negative, close
6 years to 18 years	On discovery	X-ray all contacts. X-ray when contact is broken. Repeat in 6 months. If negative, close.

cont'd)	Age	Tuberculin Test	X-ray
	Under 1 year	When 1 year of age	X-ray on discovery. Repeat in 6 months. When contact is broken, x-ray in 6 months. If negative, close

Individuals whose chest x-ray findings are positive sometimes delay seeking medical care. In such instances nurses may use their own judgment in follow-up of contacts before clinical diagnosis of the suspected case is made. It is suggested that they err on the side of safety rather than otherwise.

Suggested reference for guidance in nursing techniques and procedures: Cady, Louise Lincoln, Nursing in Tuberculosis, W.B. Saunders Company, Philadelphia, 1948

D. MATERNITY SERVICE

1. Public health nursing functions in maternity

Differences in various phases of the public health nursing program grow out of the actual needs of each age group or health conditions. They are reflected in the activities of the general public health nurse, as follows

- a. Assisting in promoting a program for premarital and pre-conceptional advice and care*
- b. Getting in touch with prospective mothers and assisting in securing medical and dental examination and supervision early in pregnancy and throughout the maternity cycle
- c. Assisting in planning and preparing for hospital or home confinement
- d. Helping to secure postpartum medical examination
- e. Giving or arranging for nursing care at delivery if at home, and for the postpartum period
- f. Teaching and supervising care given by relatives, attendants and midwives
- g. Helping the family to carry out specific medical advice for the mother's and baby's care
- h. Helping the family, if eligible, to utilize special provisions for maternal care, such as those available through federal and state government**

A constructive maternal and child health program offers unlimited opportunities to promote health work and to put into practice, measures that will effect not only a reduction in morbidity and mortality, but will raise the standards of positive health for the community

*National Organization for Public Health Nursing, Public Health Nursing Functions, The Public Health Nursing Curriculum Guide, New York p. 17, Point No. 1, 1942.

**National Organization for Public Health Nursing, Functions in Public Health Nursing, Public Health Nursing, New York, June 1944.

The nurse who works in a generalized public health nursing program, giving service in all fields of nursing has an excellent approach to a successful maternity nursing service

"Maternity nursing service includes the care and guidance of of the mother through pregnancy and delivery, and the care of the mother and newborn during the postpartum period, through the sixth week following delivery, and for at least three months thereafter

"Antepartal or prenatal care is the care and supervision given to a pregnant woman so that she may pass through pregnancy with the minimum of physical discomfort, and a maximum of mental and physical fitness and at its termination with the reward of a well baby, and the knowledge whereby mother and baby may be kept well. This is accomplished through the combined efforts of the obstetrician, the nurse, and the expectant mother

"Prenatal care may be considered the foundation for the normal development, adequate growth, and good health of the baby. It is during this formative period that the teeth, bones and various systems of the body have their beginnings, as well as the foundations for his future health. For the mother, adequate prenatal care aids in stabilizing the daily health. As pregnancy advances, the demands of the fetus increase. Since individuals react differently to pregnancy, this supervision is of the utmost importance in detecting these reactions. This supervision not only helps to relieve discomforts and to prevent accidents and complications, but also aids in insuring a more rapid convalescence and continued good health."*

2. Administration of maternity nursing service

a. Determining the problem

The New Mexico maternal mortality rate for 1947 was 2.2 per 1,000 live births

The infant mortality rate for 1947 was 68.6 per 1,000 live births**

Evaluation of the maternity and infancy problem and its relation to other problems in the community will be clarified by a community survey. It can be determined then how much time should be devoted to this phase of the total program. It may serve as a guide in case selection. A survey for determining the maternity problem should include

*Zabriskie, Louise, R.N., and Eastman, N.J., M.D., "Nurses Handbook of Obstetrics, Eighth Edition, Philadelphia, J.B. Lippincott Company, p. 158.

**Child Health Services in New Mexico, Report of the American Academy of Pediatrics Study of Child Health Services in New Mexico, New Mexico Health Officer, State of New Mexico Department of Public Health, Santa Fe, N.M., Vol XV, No. 3, September, 1947.

the following information

- (1) Number of pregnancies during previous year
- (2) Number and causes of maternal deaths during previous year
- (3) Number of infants who died during the previous year
 - (a) First month of life
 - (b) First year of life
 - (c) Chief causes of infant death
- (4) Number of premature births
 - (a) Chief causes
- (5) Number of stillbirths
 - (a) Chief causes
- (6) Percentage of births
 - (a) White
 - (b) Colored
 - (c) Foreign born parents
- (7) Percentage of births attended by
 - (a) M.D.
 - (b) D.O.
 - (c) Midwives
 - 1) Nurse
 - 2) Native
 - (d) Other
- (8) Percentage of deliveries occurring in
 - (a) Hospital
 - (b) Home
- (9) Available personnel for maternity and newborn care
 - (a) Nursing service
 - 1) Types of public health nursing service
 - 2) Area served by public health nurse
 - 3) Number of available private duty nurses
 - 4) Number of available hourly nurses
 - 5) Number of available nurse-midwives
 - (b) Other
 - 1) Number of available physicians
 - 2) Number of available osteopaths
 - 3) Number of available native midwives
 - 4) Other
- (10) Facilities for maternity and newborn care
 - (a) Number of maternity beds available in hospitals
 - (b) Number of maternity beds available in nursing homes
 - (c) Number of bassinets available for infants in hospitals
 - (d) Number of bassinets available for infants in nursing homes
 - (e) Facilities available for care of premature infants
 - (f) Number of incubators

b. Medical relationships

Every pregnant woman reported to the public health nurse should be contacted, providing that the approval of the physician in charge is obtained. If no physician is in charge, an important part of the content of this first nursing visit will be to explain the values of early medical and dental service

c. Case referral

When the maternal health program is established, the public health nurse will wish to contact cases early for most effectual teaching. Family health work obviously offers many opportunities to contact maternity cases.

(1) Usual methods of case finding are

(a) By the nurse

- 1) As a part of routine home visiting
- 2) At clinics and conferences

(b) Reported by

- 1) Private physicians
- 2) Community agencies such as hospitals, clinics, Red Cross service, factories employing women, church and school organizations, insurance companies, and social agencies (a routine referral plan may be developed)
- 3) School, orthopedic, tuberculosis or industrial nurses who have access to the home
- 4) Lay organizations such as public health council or nursing advisory committee members
- 5) Interested persons, as friends, relatives, neighbors, or other patients
- 6) General methods of public information such as newspaper publicity, radio broadcasts and talks before various groups
- 7) The patients or their families

d. Case selection

A careful selection of patients for home visits is imperative, especially in rural New Mexico where the case load is heavy and the area served is great. In selecting cases, first consideration should be given to the following patients

- (1) Women pregnant for the first time
- (2) Women gravida VI or more
- (3) Women under 20 years of age or over 35
- (4) Women who have been pregnant before, but who have never given birth to a live child
- (5) Women who have had more or less severe complications with previous pregnancies or show signs of complications in this pregnancy
- (6) Women whose present pregnancy is complicated by disease such as heart disease, diabetes, syphilis, gonorrhea, tuberculosis, anemia, gall bladder and kidney disease
- (7) Women in the lower income groups who are unable to provide themselves with adequate medical, dental and nursing care
- (8) Cases to be delivered by native midwives

e. Methods of nursing care and supervision

(1) Home visits by the nurse to the patient

(a) Advantages

The patient is inclined to be more at ease in her own home environment. The nurse has an opportunity to observe family relationships and problems of

other members of the family as well as their implications in this pregnancy. The nurse as a friend and health counsellor has an opportunity to gain the confidence of the mother so that she is encouraged to talk about her health interests and problems, and eventually her pregnancy. Teaching opportunities can be utilized according to the individual needs of the patient. At home, the mother will feel free to ask questions and discuss her personal problems. She may be timid and find it difficult to express herself unless she is on familiar ground

(b) Disadvantages

Home visiting is time consuming. Since the pregnant woman is essentially a well person the nurse often fails to find her at home. At other times the nurse may find the patient preoccupied with matters which seem to be of greater importance than her pregnancy (law of readiness)

(2) Office visits by the patient to the nurse

(a) Advantages

The patient is mentally set for the interview because she has planned for it. The nurse's time and energy are conserved so that her services can be extended to those patients who are unable to come into the office. Furthermore, the patient will probably learn to appreciate the value of the service through her own effort in seeking special information on maternal and child care which will help her to institute a plan of living to meet her needs. If she receives help with her immediate problems, she may learn through this experience to consult the nurse more frequently regarding the health problems of other members of her family. The nurse's office may be the more convenient place for the interview as there is less confusion than in the home of the patient. The patient may desire privacy and counsel of another woman to talk over some of the more intimate problems which pertain to her own health and that of family members

(b) Disadvantages

The total family situation is less apparent to the nurse during the office interview. The nurse may be handicapped by not having information obtained by the general observations made in the home

(3) Group instruction of mothers through classes and clubs

(a) Advantages

The nurse's time is conserved because she can give general information on a common subject, the general and specific aspects of maternal and child hygiene to a larger group of women at one time. Group discussion affords an opportunity for demonstration, display of exhibits, use of posters,

models and films, all of which are excellent media of education. The group method affords the patient an opportunity to exchange ideas and make social contacts. It often motivates interest in health education by stimulating the patient to seek further information on subjects pertaining to health

(b) Disadvantages

It is sometimes impossible to answer the questions that are of primary concern to each individual patient at the time it is concerning them

(4) Nursing assistance to the physician in the conduct of the maternity conference

(a) Advantages

The significance of the physical and obstetrical examination may not be interpreted by the physician. The importance of regular visits by the prospective mother to the conference may need to be emphasized. The patient may be encouraged to talk freely and spontaneously in order for the physician to obtain an insight into her particular situation

(b) Disadvantages

Many teaching opportunities cannot be utilized in the conference as the nurse has little opportunity to adjust her teaching to the environmental influences in the home effecting the mother's welfare

(5) Visit spacing

The need of the patient should determine the frequency and type of visit. The spacing of visits depends on such factors as the following

(a) History

The previous obstetrical history is important, especially if the patient has had repeated fetal or neonatal loss, difficult or premature labors, antepartal bleeding, or malpresentations

(b) Symptoms

The presence of albumin in the urine, increased blood pressure, presence of edema, persistent nausea and vomiting, persistent headache, blurred vision, vaginal bleeding, rapid gain in weight, excessive irritability, anxiety, depression and maladjustment to pregnancy are significant symptoms which modify the plan for visiting

(c) Month of pregnancy and gravida

Visits should be made more frequently to the mother who received care late in pregnancy in order to prepare her for labor and delivery. The woman pregnant for the first time, especially if she is under twenty-one, or over thirty-five years of age, or gravida of six or over, merits special attention

(d) Medical supervision

The patient under medical supervision and/or attending mothers' classes will probably need only one or two antepartal visits to help her adapt the instructions



to her home. The nurse will check preparations which the patient has made for delivery. The patient who is lax in visiting her physician cannot be depended upon to report symptoms or carry out medical instructions, therefore, more visits will be required

(e) Economic and social needs

Family problems such as insufficient income, crowded and poor home hygiene, illness of other family members, inadequate equipment, pregnancy out of wedlock, marital difficulties, and the lack of transportation facilities to secure medical care may indicate the need for more frequent visits

(f) Group activities

The antepartal conference which offers opportunities for individual instruction, or the existence of mothers' classes will supplement numerous home visits*

(6) The interview and supervisory visit

THE LAW OF READINESS SUPERSEDES ALL OTHER FACTORS IN CONDUCTING THE MATERNITY VISIT

A complete nursing visit should be attempted when the patient seems ready for it. If the patient is under medical supervision, only when orders (standing or individual) have been obtained from the physician. Data to be obtained, if feasible, should be in accordance with the suggested outline for recording the maternity visit on the Family Nursing Service Record

3. Antepartal service

The part the public health nurse plays in her relationship to the patient and the general instructions she will give regarding antepartal hygiene and diet is in conformity with local medical opinion as embodied in the standing orders which have been secured by the local health officer for the guidance of the nursing staff. (See suggested form for standing orders.) Such standing orders should cover the educational content which the nurse may teach. The nurse will want to visit individual physicians frequently to secure specific instructions in regard to their patients. Many physicians will recognize the public health nurse as a competent assistant and teacher who can help the antepartal patient to understand, accept and practice good hygiene. The reporting of symptoms which may arise during pregnancy is important in order that the physician may correct or relieve abnormalities or discomforts, advise medication, diet, and treatments necessary to promote the mother's well-being, direct her activities so as to conserve her energy, and meet satisfactorily the problems that disturb her peace of mind.

a. The antepartal nursing visit

The teaching content of the antepartal visit should be in accordance with the patient's problems and interest. It is suggested that the teaching guide be used as a basis for the

*Manual on Maternal, Infant and Child Health for Public Health Nurses, State Department of Public Health, Springfield, Illinois.

a.

(I) SUGGESTED OUTLINE FOR CONTENT OF ANTEPARTAL VISIT

<p>First visit Before 4th month</p> <p>Explanation of nursing service Anatomy and physiology of re- productive organs Plans for delivery attendant Early registration for midwife delivery Antepartal medical and dental care What it is Why important Hygiene of pregnancy Nutrition Elimination Rest and sleep Fresh air Bathing Exercise Recreation Clothing Mental hygiene Family relationships Comfort of mother Nausea and vomiting Heartburn Frequency Safety measures Avoid over-activity and inter- course at time of usual men- strual period Avoid cathartics, enemas and douches unless ordered by physician In case of vaginal bleeding, im- mediate bed rest, call physician</p>	<p>First visit Between 4th & 6th month</p> <p>Explanation of nursing service Anatomy and physiology of re- productive organs Plans for delivery attendant Early registration for midwife delivery Antepartal medical and dental care What it is Why important Hygiene of pregnancy Nutrition Elimination Rest and sleep Fresh air Bathing Exercise Recreation Clothing Mental hygiene Preparation of breasts Advantages of breast feeding Comfort of mother Varicosities Hemorrhoids Cramps in legs Family planning for the new baby "Quickening" In event of vaginal bleeding or profuse discharge, immediate bed rest, call physician</p>	<p>First visit Between 6th & 7th month</p> <p>Explanation of nursing service Anatomy and physiology of re- productive organs Plans for delivery attendant Antepartal medical and dental care What it is Why important Prompt registration with mid- wife attendant Hygiene of pregnancy Nutrition Elimination Rest and sleep Fresh air Bathing Exercise Recreation Clothing Mental hygiene Preparation of breasts Advantages of breast feeding Bathing Avoidance of tub baths and sexual intercourse six weeks preceding and following deliv- ery Plans and preparation for de- livery Hospital Supplies needed When to start to hospital Plans for other children Home Supplies needed Assist in selection and sug- gest preparation of room for confinement Plan for care of mother, newborn, and rest of house- hold Family planning for the new baby Baby's clothing Baby's supplies Bath tray Bed Corner or room Chest, box or drawer In event of vaginal bleeding, or profuse discharge, immediate bed rest, call physician Comfort of mother Varicosity Hemorrhoids Cramps in legs</p>	<p>First visit At 8th month</p> <p>Explanation of nursing service Anatomy and physiology of re- productive organs Plans for delivery attendant Antepartal medical and dental care What it is Why important Prompt registration if planning for midwife attendant Hygiene of pregnancy Nutrition Elimination Rest and sleep Bathing Fresh air Exercise Recreation Clothing Mental hygiene Preparation of breasts Advantages of breast feeding Avoidance of tub baths and sexual intercourse six weeks preceding and following confine- ment Plans and preparation for deliv- ery Hospital Supplies needed When to start to hospital Plans for other children Home Supplies needed Assist in selection and sug- gest preparation of room for confinement Plan for care of mother, newborn, and rest of house- hold Family planning for the new baby Baby's clothing Baby's supplies Bath tray Bed Corner or room Chest, box or drawer Tray for mother In event of vaginal bleeding, or profuse discharge, immediate bed rest, call physician Comfort of mother Varicosity Hemorrhoids Cramps in legs Swelling of feet Shortness of breath Frequency Lightening, explained Labor and what to expect Value of medical postpartal examination Planning for well child super- vision Value of birth registration</p>	<p>First visit At 9th month</p> <p>Content of visit when limited to this degree will need to be based on the needs of the patient</p>
<p>Second visit Before 6th month</p> <p>Review in accordance with find- ings and contents of previous visit Baby's clothing Baby's supplies Bath tray Bed Corner or room Chest, box or drawer Family planning for the new baby "Quickening" Preparation of breasts Advantages of breast feeding Comfort of mother Varicosities Hemorrhoids Cramps in legs</p>	<p>Second visit Before 7th month</p> <p>Review in accordance with find- ings and contents of previous visit Avoidance of tub baths and sexual intercourse six weeks preceding and following deliv- ery Plan and preparation for deliv- ery Hospital Supplies needed When to start to hospital Plans for other children Home Supplies needed Assist in selection and sug- gest preparation of room for confinement Plan for care of mother, newborn, and rest of house- hold Family planning for the new baby</p>	<p>Second visit At 8th month</p> <p>Review in accordance with find- ings and contents of previous visit Comfort of mother Swelling of feet Shortness of breath Frequency Lightening, explained Labor and what to expect Value of medical postpartal examination Planning for well child super- vision Value of birth registration</p>	<p>Second visit At 9th month</p> <p>Review in accordance with find- ings and contents of previous visit Mother's tray Plan with family for notify- ing nurse when patient has de- livered, or returned to the home Discuss habit formation of child Value of eye prophalaxis</p>	
<p>Third visit Before 7th month</p> <p>Review in accordance with find- ings and contents of previous visits Avoidance of tub baths and sexual intercourse six weeks preceding and following deliv- ery Plans and preparation for de- livery Hospital Supplies needed When to start to hospital Plans for other children Home Supplies needed Assist in selection and sug- gest preparation of room for confinement Plan for care of mother, newborn, and rest of house- hold Family planning for the new baby</p>	<p>Third visit At 8th month</p> <p>Review in accordance with find- ings and contents of previous visits In event of vaginal bleeding, or profuse discharge, immediate bed rest, call physician Comfort of mother Varicosity Hemorrhoids Cramps in legs Swelling of feet Shortness of breath Frequency Lightening, explained Labor and what to expect Value of medical postpartal examination Planning for well child super- vision Value of birth registration</p>	<p>Third visit At 9th month</p> <p>Review in accordance with find- ings and contents of previous visits Mother's tray Plan with family to notify nurse when patient has deliv- ered or has returned from hos- pital to the home Discuss habit formation of child</p>		
<p>Fourth visit At 8th month</p> <p>Review in accordance with find- ings and contents of previous visits In event of vaginal bleeding, or profuse discharge, immediate bed rest, call physician Comfort of mother Varicosity Hemorrhoids Cramps in legs Swelling of feet Shortness of breath Frequency Lightening, explained Labor and what to expect Value of medical postpartal examination Planning for well child super- vision Value of birth registration</p>	<p>Fourth visit At 9th month</p> <p>Review in accordance with find- ings and contents of previous visits Mother's tray Plan with family to notify nurse when patient has deliv- ered or has returned to the home Discuss habit formation of child</p>			
<p>Fifth visit At 9th month</p> <p>Review in accordance with find- ings and contents of previous visits Mother's tray Plan with family for notifying nurse when patient has deliv- ered or has returned to the home Discuss habit formation of child</p>				



visit content of instruction as regards general hygiene

Blood serology, blood pressure and urinalysis are to be included in the procedures if the physician has given orders to include them (see procedures). When urinalysis is included in the visit, first consideration should be given to selecting a work place where there will be no possibility of contaminating food, dishes, sink or utensils. The bedroom or bathroom is preferable, although the kitchen may have to be used. The place should be selected also for its convenience to facilities for hand washing and disposal of waste.

Bag technique for the antepartal visit should correspond to that adopted for all other home visits. Recording of visit (see suggested outline)

(2) A suggested form for standing orders in maternity and newborn services

Physician's Name _____ Address, office: _____
Telephone office _____ Residence _____ Office hours _____

I. Service for nurse to give to antepartal and postpartal patients
Serology Yes _____ No _____
Urinalysis Yes _____ No _____
Blood pressure Yes _____ No _____

II. Instructions to be given by the nurse to your antepartal patients
Frequency of office visits: Patient should report to physician
by _____ month of pregnancy and return.
First trimester every _____ month
Second trimester every _____ month
Third trimester every _____ week

Nutrition: Well balanced diet for normal patients recommended
to include that of the publication, "Foods needed
Daily During Pregnancy and While Breast-Feeding the
Baby." (Copy enclosed) Yes _____ Other _____

Fluids: At least 8 glasses daily, or _____
Condiments: Restriction of salt after _____ month. or _____
Nausea and Vomiting: Frequent small meals (6 or _____ daily).
Black coffee, tea with sugar and dry crackers before
getting up in the morning. Diet high in carbohydrates
(simple sugar, hard candy, etc.) low in fat, or _____

Heartburn: Frequent small meals, fried and fatty foods restrict-
ed. Six glasses of water between meals, adequate
elimination daily. If this fails, _____

Constipation: Regular toilet habits _____ prunes and senna _____
Other _____

Hemorrhoids: Report symptoms to physician. Avoid constipation.
Lie with hips elevated on one or two pillows and apply
ice cold cloths, witch hazel compresses or ice bag to
rectum. Other _____

Backache - heavy abdomen: Rest with feet elevated several times
a day _____ Maternity corset _____ Abdominal
binder _____ Nurse to instruct patient
in regard to adjusting _____

Cramps in extremities: Patient to report to physician _____

Varicosities: Patient to report such symptoms to physician. Have
patient lie down and elevate legs for short periods at
frequent intervals during day. Apply Ace bandages,
Yes _____ No _____ Other _____

Breast Care: Begin after 7th month, or _____
Demonstrate daily care of nipples. Routine: Wash hands,
cleanses nipples with mild white soap and water, dry
thoroughly and apply albolene or _____
Brassiere: _____ Home-made breast support _____

Marital Relations: Avoid at time regular menstrual period would occur and after 7th month, or _____
Douches only by special order at any time during the maternity cycle Yes _____ No _____

Bathing: Avoid tub bath after 7 months or _____

Symptoms of Toxemia: Report symptoms to physician. List of cardinal symptoms: Persistent nausea, acid odor to breath and urine, rise or change in blood pressure, headache, visual disturbance, edema, albumin in urine, epigastric pain, increase in nervousness, twitching

Instruct patient to rest as much as possible _____.

Take fluids _____ glasses a day _____. Diet of milk, cereals, vegetables, stewed fruits and oranges. Meat or eggs once a day. Other _____

Eliminate salt and condiments from diet. _____ Prepare foods without salt, unsalted butter, other _____

Antepartal bleeding or premature rupture of the membranes: Notify physician. Put patient to bed. Other _____

III. Check the following routines you wish your patient to follow during the post-partal period:

Uncomplicated patient to remain in bed _____ days. Patient may get up to toilet the _____ day. Patient to wear an abdominal support. No _____ Yes _____. Breast support _____. Wash nipples with boiled water _____
Other _____

Cracked nipples: Report to physician. Apply compound tincture of benzoin _____. Other medication _____.
Nipple shield _____. Milk expressed _____
manually _____ breast pump _____

Engorgement of breasts: Supporting binder or brassiere _____
Restrict fluids except fruit juices _____ Apply ice bag _____
When establishment of breast supply is not desired apply: restricting binder _____ ice _____

Vulva care: Boiled water and cotton sponges _____
Soap and water _____ Other _____

Diet of normal mother: Follow outline of New Mexico State Health Department publications, "Foods Needed Daily During Pregnancy and While Breast-Feeding the Baby." Yes _____
Other _____

Elimination: S.S. enema _____ day _____ Cathartic: Day _____
amount and type _____ milk of magnesia _____
Other _____

Lochia, if foul or scanty: Report to physician, elevate head of bed _____ Other _____

Postpartal exercises: Yes _____ No _____
Recommendation _____

Bathing: Tub baths after _____ weeks

Marital Relations: After _____ weeks

Postpartal examination at _____

IV. Instructions for the care of the infant

Care of the cord: Cord dressing not changed unless indicated
until cord is off _____

Dry dressing _____ . Other _____

Care of the eyes: None _____ . Other _____

Discharging eyes: Report to physician immediately. Take smear

Other _____ .

Bath: Oil _____ number of days _____ .

Soap and water _____ Other _____ .

Constipation: Consult physician. Do not give cathartics.

Other _____

Mouth care: Report abnormalities to physician. Inspect daily but
do not wash. Other _____

Feeding: To breast _____ hours after delivery and then every
_____ hours. Demand feeding schedule -

Yes _____ No _____ . Number of night feedings _____ .

If supply of breast milk fails, teach mother to prepare

_____ until she can get in touch with the physician.

Boiled water: Ounce _____ every _____ hours,

Karo added - No _____ Yes _____ amount _____

V. Instructions for care of premature infant

Standing procedures suggested by New Mexico State Depart-
ment of Public Health and approved by New Mexico State
Obstetrical and Pediatrics Societies, may be used -

Yes _____ No _____

VI. After-care of the infant: Infant to report for well baby supervi-
sion. First _____ subsequently _____, or other

Recommendation regarding immunization for whooping cough
at _____, smallpox _____, diphtheria _____

Other _____

Orange or tomato juice: Add at the end of second week or
and give _____

ounces a day, _____ increase to _____

Cod liver oil or other source of Vitamin D: Begin at second or
third week _____ and give _____ a day.

Increase to _____ or _____

(Knowledge of your general routine will assist the nurse
to interpret the suggestions which you make to the mother)

Expectant mothers who have been patients of private physicians and who have had an opportunity to attend group instruction conducted by qualified public health nurses of community health agencies, have expressed appreciation for the educational experience. In event group instruction is offered by public health nurses, would you be interested in referring your patients?

Yes _____ No _____.

Any complications observed by the nurse will be reported to the physician immediately.

Would you like a written report of each nursing visit?

Yes _____ No _____.

Date _____

Physician's Signature

(3) Procedure for admitting a new clinic patient

(a) Purpose

- 1) To secure accurate information regarding patient's medical, obstetrical and social history in order to insure the best possible care for the maternity patient
- 2) To provide patient education in the essential aspects of good maternal care
- 3) Acquaint patient with available maternity service

(b) Equipment

- 1) Records as follows: patient's clinic record, appointment card, mother's supply list, index card, forms for serology and smear specimens
- 2) Fountain pen with ink
- 3) Blotter
- 4) Registration book
- 5) Appointment book

(c) Procedure

- 1) Take obstetrical and medical history as indicated on the patient's record (follow directive for clinic record)
- 2) Teaching content of this visit should be in accord with suggested teaching outline for antepartal service
- 3) Take blood for serology and estimate hemoglobin (according to clinic physicians orders)
- 4) Ask patient to collect urine sample in urine specimen bottle. Check for albumin and sugar. Instruct patient to wash her hands before leaving lavatory
- 5) Give patient a clean wrapped bottle, with a good stopper. Explain to the patient that she is to bring clean urine specimen collected the morning of clinic visit with her at the time of each clinic visit
- 6) If the patient is to have her initial physical examination on the day she registers, follow procedure for initial physical examination
- 7) If the patient is to have her initial examination on a subsequent visit, advise her to keep her appointment as punctually as possible
- 8) Fill out date of next appointment on appointment card, and in appointment book. Show card to the patient. Explain the value of keeping each appointment and the necessity of bringing appointment card to clinic
- 9) Give the patient her appointment card
- 10) Dismiss patient

(4) Procedure for initial physical examination

(a) Purpose

- 1) To determine the physical status of the patient
- 2) In primipara, especially, to determine pelvic type
- 3) To begin a program of adequate antepartal care

(b) Equipment

- 1) Admission room. Same as in procedure for "admission of a new patient"
- 2) Laboratory routine. Same as in procedure for "admission of a new patient"
- 3) In dressing room. Dressing cubicle and examination gown
- 4) In examining room
 - a) Examination cubicle
 - b) Tyco's and stethoscope
 - c) Paper napkin
 - d) Ophthalmoscope
 - e) Flashlight
 - f) Tongue depressor
 - g) Percussion hammer
 - h) Pelvimeter
 - i) Glove, size 7½ (usual)
 - j) Glass slide and applicator for taking smear
 - k) Speculum
 - l) Basin for soiled instruments
 - m) Basin for soiled gloves

(c) Procedure

- 1) In admission room take and record in column specified for antepartal physical examination the following: temperature, pulse, respiration, height, weight, urinalysis (examine for sugar and albumin)
- 2) Request patient to go into dressing cubicle and remove all clothing except her shoes and stockings (stockings should be rolled down) and to put on a clean examination gown
- 3) Ask patient to wait in dressing room until she is called to examining room
- 4) Invite patient into examining room, place record on the desk, and assist the patient to sitting position on examining table
- 5) The nurse may take the blood pressure, subject to the physician's approval
- 6) The doctor may wish to do serology at this time (form was completed when history was taken). The doctor examines the eyes, ears, nose and throat, reflexes, and records the findings on the record (may dictate)
- 7) The doctor examines the breasts and nipples, the lungs and heart, and records findings

- 8) Nurse may assist the patient to a reclining position and expose the abdomen for examination. The doctor observes and records the position of the fetus and the engagement, the height of the fundus, the fetal heart rate and takes external pelvic measurements
 - 9) Nurse places patient in lithotomy position and drapes for vaginal examination
 - 10) The doctor does internal examination and pelvimetry, takes smear (form has been filled out)
 - 11) Following the examination, the nurse assists the patient to a sitting position on the foot of the table
 - 12) The nurse makes certain the entire examination has been recorded before the doctor leaves the examining room
 - 13) If the patient registered on a day previous to her initial physical examination the teaching content should be reviewed in accordance with the problems, questions, and needs of the patient. The doctor's advice should be interpreted to the patient
- (5) Procedure for revisit of a patient following registration and initial physical examination
- (a) Purpose
 - 1) To observe the general condition of the patient in order to take care of any signs and symptoms of the impending toxemia or other medical, surgical, or obstetrical complications
 - 2) To instruct the patient regarding personal hygiene, preparation for delivery, preparation for the coming baby, and any problems that the mother might present for discussion
 - (b) Equipment
 - 1) In the admission room -
 - a) Registration card
 - b) Patient's record
 - c) Thermometer tray as set up in the clinic
 - d) Scales
 - 2) In laboratory -
 - a) Urinalysis tray equipped
 - b) Urine specimen from patient
 - c) Clean urine specimen bottles
 - 3) In examining room -
 - a) Examining table
 - b) Drape sheet with paper lining
 - c) Tycos and stethoscope
 - d) Paper napkin
 - e) Pelvimeter
 - f) Patient's record

(c) Procedure

- 1) Greet patient, as she enters admitting room, showing personal interest in her
- 2) Ask patient for her appointment card when she enters
- 3) Take record from file and attach appointment card and number slip to front cover. Open chart to page 2
- 4) Take urine specimen from patient, and take it to the laboratory. Test for albumin. If patient has not brought a specimen have her collect one. Teach patients to wash their hands before leaving bathroom
- 5) While in laboratory get a clean specimen bottle and return it to the patient. She should put it in her purse to avoid misplacing it
- 6) Take patient's temperature, pulse, and respirations; record
- 7) Weigh patient with coat and shoes removed. Record weight
- 8) Ask patient to go to the bathroom and empty her bladder unless she has just done so
- 9) Have patient remove panties and girdle, if she has them on, in the dressing cubicle, and when called to go into the examining room patient may leave all belongings except purse in the cubicle or in a paper sack
- 10) Place record in rack outside examining room door. The nurse in the examining room assists patient to sitting position on the table. Cover her with paper lined drape sheet to the waist
- 11) Doctor or nurse, whichever is conducting conference, will
 - a) Read notations of previous visits, observe whether or not patient has been given medications, and note all remarks recorded on the back page of the record
 - b) Take patient's blood pressure and record
 - c) Examine breasts. Antepartal breast care instruction should be given after the beginning of the seventh month. Have patient lie down
 - d) Keeping patient well draped, pull up dress and examine the abdomen to determine size and position of fetus. Listen to fetal heart and count its rate
 - e) Measure height of fundus, record
 - f) Place pelvimeter with contaminated ends over edge of table (to be placed in boiler or sterilizer after each use)

- g) Examine extremities for edema, varicose veins, or any other suspected or possible pathology
- h) Wash hands
- 12) Nurse will assist patient to sitting position on end of table
- 13) Teaching content of each visit should be in accord with the readiness of the patient and the suggested teaching outline for antepartal service
 - a) Check mother's supply list with patient and record supplies patient has procured since last visit
- 14) Assist the patient from the examining table, ask her to dress
- 15) Prepare examining room and table for another patient
- 16) Schedule next appointment in accordance with patient's individual problems and month of gestation
- 17) Record date of next appointment on appointment card and in appointment book
 - a) 1st to 7th month normal cases should be seen each month
 - b) 7th and 8th month normal cases should be seen every two weeks
 - c) 9th month normal cases should be seen each week
- 18) Give patient appointment card and again explain to the patient the values of regular care
- 19) Dismiss the patient

(6) Suggested form for reporting findings of clinic patient

Name: _____ (last) _____ (first) _____ Husband: _____

Age: _____ Gravida _____ Para _____ Date registered _____

First day of last menstruation _____ Estimated date due _____

Physical findings: _____ General condition _____

Usual Weight: _____ lbs. First weight _____ lbs. Present weight _____ lbs.

First blood pressure _____ Date: _____ Highest blood pressure _____

Serology: Date _____ Result _____ Vaginal smear: Date _____ results _____

Microscopic urinalysis: _____ Blood Chemistry _____
Date _____ results _____

Hemoglobin _____

Pelvic measurements _____

Interspinous _____ Height of Symphysis _____

Intercrestal _____ Outlet _____

External conjugate _____ Diagonal conjugate _____

Pelvic Type: clinical impression X-Ray diagnosis _____

Remarks: _____

Signed _____

4. Postpartal service

Record all visits in accordance with directions for recording maternity notes on Family Nursing Service Record

a. General policies

- (1) Make the first postpartum visit to home deliveries within 24 hours after delivery (no Sunday or holiday) or as soon thereafter as possible
- (2) Subsequent visits to normal patients should preferably be made the 5th and 9th days postpartum and one month after delivery, (clinic or home)
- (3) Patients with complications should be visited as frequently and often as their condition indicates
- (4) Follow "standing orders" and report abnormal condition of the patient to physician
- (5) Hospital releases should be visited as soon as possible following hospital discharge. (Referral plan may be developed locally between health department, hospitals and physicians)

b. Procedure for first postpartal visit

(1) Purpose

- (a) To ascertain condition of mother and baby
- (b) To teach the family the importance of cleanliness, and to demonstrate, (when indicated) usual care of mother and baby
- (c) To give indicated nursing care

(2) Equipment

- (a) Nursing bag completely equipped
- (b) Newspaper
- (c) Newspaper bag
- (d) Cotton

(3) General

- (a) After washing hands, take the apron from bag and put it on.
- (b) Take mask from bag, open napkin in which it is folded, and place on newspaper for equipment field. Put on mask
 - 1) It is recommended that clean masks made as directed in American Journal of Nursing, - January, 1949, Page 33, be wrapped in a paper napkin and included in the nursing bag, one for each postpartal visit. Soiled masks to be placed in a small paper sack and carried in the hand-washing compartment of the nursing bag. Masks should be boiled when laundered
- (c) Take from bag the following items: tycos, stethoscope, three folded napkins, rectal and mouth thermometers, cord dressing, baby scale. Put baby equipment in one napkin

(4) Mother

- (a) Following the procedure for thermometer technique, take the patient's temperature
- (b) While the thermometer is registering, count the pulse, and respiration and take the blood pressure (when ordered). After removing cuff from arm, discard soiled napkin and replace it with a clean one. Put tycoos on equipment field
- (c) Take thermometer from patient's mouth, read, and complete procedure for mouth and thermometer technique
- (d) Demonstrate general care to the attendant
- (e) Note general condition
- (f) Examine breasts and nipples
- (g) Check height and condition of uterus
- (h) Inspect perineum, note condition of sutures
- (i) Demonstrate perineal care
- (j) Check character of lochia
- (k) Check elimination of kidneys and bowels
- (l) Discuss nutrition, emphasis on lactation
 - 1) Discuss values of breast feeding
- (m) Exercise in accord with medical orders
- (n) Discuss restriction of visitors
- (o) Check medication

(5) Infant

- (a) Wash hands
- (b) Have family get two diapers and a band ready for use
- (c) Weigh infant wearing clean diaper and band
 - 1) Tie small knot in one corner of weighing diaper
 - 2) Place baby with head at knotted end of the diaper
 - 3) Tie two corners at side in a secure square knot across baby's chest
 - 4) Bring free corner of diaper up between baby's legs and pin between ends of knot
 - 5) Raise baby to eye level to read scales, hand under back
- (d) Measure infant length. Place infant on diaper and draw line for head and feet of infant, measure distance between
- (e) Note head, shape, sutures, fontanelles
- (f) Inspect nose
- (g) Check ears
- (h) Inspect mouth, tongue, gums, check for swallowing
- (i) Neck
- (j) Take temperature by axilla (see procedure, page _____)
- (k) Chest, inspect shape, should be well rounded, (barrel shaped)
- (l) Umbilicus or cord
- (m) Genitalia, check for voiding
- (n) Male
 - 1) Check foreskin
 - 2) Testicles palpable in scrotum

- (o) Female
 - 1) Labia majora and labia minora
 - 2) Check for bleeding and white mucoid discharge
- (p) Anus
 - 1) If rectal temperature, take now (use procedure on page_____)
- (q) Joints
 - 1) Inspect and try out function
 - 2) Note contour of the buttocks and level of gluteal folds (asymmetry may indicate dislocation of the hip joint)
- (r) Bones
 - 1) Feel clavical throughout length
 - 2) Palpate vertebrae
- (s) Muscles
 - 1) Check extremities (pull on legs when flexed, palate when extended, test for inequality of pull or tone)
- (t) Abdominal tone (palpate when infant cries)
- (u) Reflexes
 - 1) Those usually present at birth. Contraction and dilatation of the pupils, consensual pupillary reflex, corneal and conjunctival reflexes, sucking and swallowing reflex usually well established
- (v) Discuss
 - 1) Feeding in accordance with physician's orders, specific or standing
 - 2) Family relationship to new baby
 - 3) Check sleeping arrangements for adequacy and safety
 - 4) Demonstrate care as indicated
- c. Procedure for second and third postpartal visits - 5th and 9th days
 - (1) Mother
 - (a) Review and observe care
 - (b) Content same as first postpartal visit
 - (c) Discuss hygiene of postpartal period
 - (d) In addition, discuss value of postpartal examination
 - (e) Advise patient to avoid sexual intercourse for at least six weeks postpartum
 - (2) Infant
 - (a) Review and observe care
 - (b) Inspect baby as during first visit
 - 1) Infant development
 - (c) Discuss habit formation
 - 1) Value of birth registration
 - 2) Value of regular well child medical supervision
- d. One month postpartal visit
 - (1) Mother
 - (a) Content same as previous postpartal visits
 - (b) To include urinalysis if ordered (standing or specific)
 - (2) Infant
 - (a) Content same as previous visit with emphasis on specific problems

e. Care of newborn baby's skin

The best way to take care of the skin of the newborn baby is the "dry" method as follows

- (1) After delivery, wipe off excess blood
- (2) Clean the buttocks with warm water when the baby's bowels move
- (3) Use boiled water to wash baby's eyes and face each day
- (4) Keep the baby's armpits and groins dry
- (5) Otherwise leave the baby's skin alone until the cord falls off, (**that** is, do not oil, bathe, or powder it)
- (6) Change baby's clothes every day. Change the diaper as often as it is wet or soiled
- (7) Give the baby a soap and water bath daily after the cord falls off
 - (a) Follow procedures outlined in publication, "Bathing Your Baby the Right Way". Do not use toothpick swabs in nostrils or ears of infant

f. Formula preparation

(1) Evaporated milk formula

The baby's food must always be clean and safe. Evaporated milk is always safe for it is heated after the can is sealed. It does not need to be boiled to make it safe for the baby

New foods must be started carefully. No two babies need the same amount of food. Some do better on one part of evaporated milk to three parts of boiled water for the first week. Then for another week one part of milk mixed with two parts of boiled water may be given. Finally, a mixture of one part of evaporated milk in sufficient quantity mixed with an equal amount of boiled water will usually provide the milk needed by most babies

The well baby will take the amount of food he needs. He usually develops his own feeding pattern of every three or four hour interval

(2) Preparing the evaporated milk formula

Individual feedings prepared just before use are the simplest

Wipe the top of a can of evaporated milk with a clean, damp cloth. Pour boiling water over the top of the can. Punch two holes in the top of the can with a clean can opener. Pour the required amount of milk directly from the can into a nursing bottle that has been boiled. Use a wide mouthed bottle if possible. Then, add the required amount of freshly boiled water. If the water is hot when added to the milk, the mixture will be warm enough for the baby

After the can of evaporated milk is open, cover it with a clean cup, a clean cloth, or wax paper. Keep in a cool place until ready to mix the next feeding

When the baby has finished his bottle, rinse bottle and nipple with cold water. Then wash both with hot soapy water and rinse thoroughly. Before the next feeding boil the bottle for 10 minutes and the nipple for 3 minutes

- (3) Adding sugar to the formula not necessary
It is wise to keep the milk mixture simple. Mixtures containing sugar will allow germs to grow more rapidly and may be more laxative. Evaporated milk and boiled water mixed will usually furnish enough energy or calories for the well baby. It is not necessary to add sugar or syrup

g. Procedure for giving perineal care*

(1) Purpose

- (a) To cleanse the skin and mucous membrane surrounding the orifices of the birth canal
- (b) To prevent infection
- (c) To promote healing if there has been a laceration
- (d) To make the patient more comfortable
- (e) To teach the person who cares for the mother the importance of cleanliness in caring for the new mother

(2) Equipment

- (a) Box of sanitary pads
- (b) Newspaper
- (c) Bedpan
- (d) Clean basin with warm water, towel, soap and cotton
- (e) Newspaper bag

(3) Procedure

- (a) Cover seat and back of chair with folded newspaper
- (b) Place over back of chair a clean towel
- (c) Arrange on seat of chair a basin of warm water, with 8 large cotton pledgets, a bar of soap on a saucer, the box of sanitary pads, and paper bag
- (d) Drape the patient with a sheet and place on bedpan
- (e) Remove soiled pad (front to back) and discard into paper bag
- (f) Wash hands under running water, for 2 minutes using soap
- (g) Without drying hands, return to bedside
- (h) With one wet pledget and white soap, cleanse the left labia from the pubis to the rectum, avoiding the introitus. Discard the pledget
- (i) Using another wet pledget and soap, cleanse the right labia in the same way
- (j) The right and left labia are then rinsed with the same motion using wet pledget without soap for each side. Two pledgets may be required for each side
- (k) With another pledget wrung as dry as possible, dry the area
- (l) Remove the bedpan and place it on a newspaper at the foot of the bed
- (m) Turn the patient on her side and dry the area about the anus, wiping from the introitus toward and over the anus

*Catholic Maternity Institute, Santa Fe, N. M.

- (n) Observe the condition of the rectum and perineum
- (o) Remove pad, by end, from box
- (p) Ask helper to place pads on patient front to back
- (q) Empty and wash the bedpan and place it between newspapers, or in paper sack, under the bed
- (r) Burn paper bag and its contents. Empty basin, fill with fresh water and put on stove to boil
- (s) Wash hands, put away cotton and soap
- (t) Record treatment and observations

h. Procedure for home attendant who gives perineal care
Persons caring for patients in the home are instructed to give perineal care as follows

(1) Equipment

- (a) Freshly boiled wash cloth
- (b) Towel
- (c) Clean basin of warm water
- (d) Newspaper bag
- (e) Newspaper

(2) Procedure

- (a) Place articles needed on chair covered with newspaper
- (b) Expose lower abdomen and upper thighs. Have patient flex and extend knees laterally
- (c) Holding pad in place with one hand, wash inner thighs, pubis and groins well with soap and water. Rinse, and dry with towel
- (d) Remove soiled pad downward and place in paper to burn
- (e) Take clean pad, by one end from box, using care to avoid touching center of the pad, and adjust
- (f) Have patient turn on side with face away from helper
- (g) Wash buttocks well and dry. Make patient comfortable. A second pad will be needed for the first day or so following delivery

i. Procedure for one month clinic examination of mother

(1) Purpose

- (a) To determine general condition of mother and observe signs and symptoms of abnormalities developing during the puerperium
- (b) To examine pelvic organs to ascertain whether or not normal involution is taking place
- (c) To discuss personal hygiene, diet, and any problems which the patient might wish to present

(2) Equipment

- (a) In admitting room, same as in procedure for "revisits"
- (b) In laboratory, same as in procedure for "revisits"
- (c) In examining room
 - 1) Examining table
 - 2) Drape sheet with paper lining
 - 3) Tycos and stethoscope
 - 4) Paper napkin
 - 5) Sterile glove
 - 6) Basin with soap solution and 5 cotton balls
 - 7) Bi-valve speculum
 - 8) Patient's record

(3) Procedure

- (a) Follow procedure for "revisit" up to examination of the abdomen. Patient should remove panties before leaving the dressing cubicle. Make all recordings on page 3 of record in space under "one-month examination"
- (b) In doing abdominal examination physician will observe any tenderness or pain. Note whether or not the uterus can be palpated, inquire regarding elimination and appetite
- (c) After abdominal examination is completed, physician will use clean equipment, not sterile, for aseptic vaginal examination
- (d) Physician withdraws speculum, rinses under running water and places in soiled instrument basin
- (e) Rinses gloved hand under running water, strips off glove and places it in container for soiled gloves
- (f) Washes hands
- (g) Physician will check lower extremities observing any swollen veins or other pathology
- (h) Nurse helps patient to sitting position on end of examining table and physician or nurse will record observations made during examination
- (i) Physician or nurse discusses diet, physical hygiene, and pertinent questions of the patient. Patient will be given an appointment to return to clinic in two months
- (j) Help patient from table and ask her to go to the waiting room when dressed
- (k) Give appointment for three-month examination, enter it on patient's appointment card and in the appointment book
- {l} Refer infant to the nearest well child conference
- {m} Dismiss patient

j. Procedure for three-month clinic examination of mother

(1) Purpose

- (a) To ascertain general condition of mother at end of the puerperium
- (b) To institute treatment if it is indicated

(2) Equipment

- (a) Same as for initial examination

(3) Procedure

- {a} Same as for initial examination
- {b} Follow through for initial examination, making recordings on page 3 of record
- (c) In doing vaginal examinations make the same observations that are indicated in the procedure for one month examination of mother
- {d} Ask if baby is going to a well baby clinic
- {e} Remind mother to register early in subsequent pregnancies. Thank patient for her cooperation
- (f) Dismiss patient

5. Premature Infant Care

"The incidence of premature birth, with its accompanying high mortality and morbidity, can be reduced by wider application of general measures to promote health and well-being in pregnancy and childbirth and of specific measures to combat abnormal maternal conditions associated with premature birth. In addition, further study is needed of these predisposing causes of premature labor, with a view to preventing premature birth or at least prolonging pregnancy until the infant reaches a weight compatible with a better chance of survival and development.

"Prenatal care by a physician begun early in pregnancy and continued at regular intervals includes advice in regard to general hygiene and diet, as well as detection and correction of abnormal conditions."*

a. General Suggestions

- (1) Report to the physician immediately, in event any of the following conditions are observed
 - (a) Any congenital abnormalities, hazardous to life, such as cleft palate
 - (b) Cyanosis
 - (c) Inability to swallow
 - (d) Vomiting; frequent, profuse or projectile
 - (e) Absence of stool within 48 hours after birth
 - (f) Failure to urinate within 24 hours after birth
 - (g) Frequent loose stools
 - (h) Presence of blood in stools
 - (i) Dehydration or general debility
 - (j) Infected or bleeding umbilicus
 - (k) Signs and symptoms of respiratory infection
 - (l) Abnormal discharge from eyes
 - (m) Skin infections
 - (n) Continued inability to maintain temperature of infant between 97° - 99°
- (2) Five to 6 drops of aromatic spirits of ammonia on a piece of cotton held under infant's nostril will serve as a respiratory stimulant. USE CARE THAT YOU DO NOT TOUCH INFANT'S SKIN. A few whiffs of the medication may be given p.r.n. Instruct family in the use of this medication
- (3) Instruct one person in the care of the baby. Instruct one person to relieve the person in charge. NO ONE ELSE TO HANDLE INFANT
- (4) Isolate baby as well as possible from everyone except attendants
- (5) Instruct attendant that infant is to be handled only as necessary for care

*Dunham, Ethel C., M.D., Premature Infants, a manual for physicians, Children's Bureau Publication No. 325, Federal Security Agency, Social Security Administration, Children's Bureau, Washington, D.C., 1948, pp. 14-15.

- (6) Weigh infant when first seen, and at least once a week thereafter
- (7) Obtain permission of physician in charge before giving any type of bath. Oil or water baths are to be given to infants only when general condition is satisfactory
- (8) Instruct family, if possible, to take infant's temperature by axilla or rectum, twice daily. If infant has diarrhea, temperature should be taken by axilla
- (9) NOTHING to be given by mouth for at least 12 hours after birth. Infants weighing less than 3 pounds, nothing to be given by mouth for at least 18 hours after birth. In case of cyanosis or respiratory embarrassment, nothing to be given by mouth for first 36 to 48 hours
- (10) Instruct family to give no medication except those specifically ordered
- (11) Follow feeding instruction specifically
- b. Loan kit for nursing care of premature infant in the home
 - (1) Purpose
 - (a) To provide necessary supplies for adequate care of the premature infant in the home for as long as special care is needed
 - (b) To facilitate nursing care
 - (2) How obtained
 - (a) Loan kits will be supplied to the county nurse by the New Mexico State Department of Public Health
 - (b) Families in which there is a premature infant may obtain the loan kit from the county nurse
 - (c) When loaning kit check duplicate supply list with adult member of family. Place one copy in pocket in loan kit lining, file one copy in county office
 - (3) Care of kit and contents
 - (a) Kit
 - 1) The kit is two regulation laundry-packs. The outside should be cleaned by wiping off with a damp cloth
 - 2) Keep kits in a clean place, not on floor
 - 3) Contents, see list with kit
 - (b) Care of contents
 - 1) Woolen shirts and stockinet bands
 - a) Make lukewarm suds and squeeze, never rub, shirts and bands in suds until clean
 - b) Rinse in same way until all soap has been removed
 - c) Squeeze out water and stretch shirts and bands well
 - d) Hang across clothesline to dry, use no clothespins
 - 2) Bed linens
 - a) Wash sheets, pads, head towels, and cotton blankets as any other material of this kind

- b) Wash woolen blankets carefully. It is not necessary, unless soiled, to wash these during use by one infant as they are protected by a sheet
- c) See care of feeding equipment under feeding
- d) See diaper care under diapering
- 3) Terminal care of supplies
 - a) Ask the family to launder all washable materials and clean all other equipment
 - b) Clean the laundry-pack
 - c) Check contents of kit
 - d) Repack kit
 - e) Return kit to local health department
 - f) Nurse and family recheck kit supplies - a copy to be kept in file and a copy in kit
 - g) Nurse has kit relaunched
 - h) Nurse repacks kit for loan
- (c) Emergency pack
 - 1) Purpose
 - a) To provide supplies necessary for immediate care of the premature infant
 - 2) Contents, from total supplies in kit, to be placed in paper sack on top of clothing kit
 - a) One pillow-case
 - b) One sheet
 - c) One quilted pad and one rubber pad
 - d) Feeding towel
 - e) One cotton blanket
 - f) One wool blanket
 - g) One of each kind of shirt
 - h) Two diapers
 - i) Small safety pin, pinned to outer shirts
 - j) Large safety pin, pinned to one of the diapers
 - k) Steri-pad
 - l) Stockinet band
 - m) Diaper pack to be wrapped in a clean diaper and placed in clean newspaper bag
 - { 1. Folded diaper (triangle)
 - { 2. Warming diaper (folded)
 - { 3. Quilted pad

c. Setting up incubator for home use

Oxygen should not be used with electricity in incubator supplied by the State Department of Public Health

(1) General considerations in temperature control

(a) Body of premature infant to be maintained between

97° - 99°

- 1) Weight - 4½ pounds incubator temperature 80°
- 2) Weight - 3 and 4 pounds incubator temperature 85°
- 3) Weight - under 3 pounds incubator temperature 90°
- 4) Very small premature infants may require incubator temperature of 95°

- (b) Avoid overheating of premature
 - 1) The room temperature does affect the baby's body temperature in the summer; it may not be necessary to use any external heat except in instances of a premature under 3½ pounds
- (2) Procedure for setting up incubator
 - (a) Supplies needed
 - 1) Incubator
 - 2) Mattress
 - 3) Taylor thermometer for incubator
 - 4) Emergency pack
 - 5) Bottles, or jars, if no electricity in home
 - (b) Procedure
 - 1) Select most convenient and adequate place for incubator
 - 2) Clean off outside of box with a damp cloth
 - 3) Set incubator on top of carrying box
 - 4) Connect with electricity outlet
 - 5) Be certain incubator is clean inside and outside, always consider outside of incubator "dirty" or "contaminated" and inside clean
 - 6) Wash hands and put on apron
 - 7) If infant has not been weighed, weigh him, protecting him from exposure, so that you will know at what temperature to adjust incubator thermostat
 - 8) Adjust thermostat
 - a) Remove copper wire from two screws on top of controller
 - b) The screw to the left (as operator faces incubator) is temperature adjusting screw. With blunt instrument, turn screw to adjust temperature to desired degree
 - c) The screw on the right is differential setting indicator. It should be set on A and left at that point. This allows 3° variation in temperature
 - d) Fasten copper wire through both screws
 - e) Frequently check Taylor thermometer for accuracy of temperature
 - f) Hang Taylor thermometer on nail with the bulb at the level of the mattress
(1 Place nail at inside head end of incubator on far wooden corner
 - g) Fill the tray at the foot of the bed with water. Keep this filled at all times
 - 9) To heat incubator non-electrically
 - a) Fill vinegar bottles or mason jars or other suitable container with hot water
 - b) Place bottles at foot of incubator behind wire partition. If incubator with electric unit is being used, tilt the light unit upright or remove bulb and guard to give room for bottles.

- c) Refill bottles as needed to maintain desired temperature. Change bottles alternately
- 10) Aids to prevent breakage of incubator glass
 - a) Avoid removing glass top halves when working in the incubator
 - b) Separate glass halves at middle when working in the incubator
 - c) Place newspaper on lower half of glass top of incubator
 - d) Place emergency pack from the loan kit on the newspaper

(3) Procedure for bed making

- {a} Place mattress in pillow-case
- {b} Lay small towel folded at the head of the incubator away from the heating unit for protection of the sheet under the baby's head.
- {c} Lay two shirts together at head of bed
- {d} Cover rubber square with quilted pad, place the upper edge of the pad up to the head towel
- {e} Place diaper, folder in a triangle twice, on top of pad
- {f} Lay second diaper, warming diaper, at foot of bed
- {g} Lay feeding towel, to be used as bib, at the head of the incubator to the left
- {h} Lay double cotton blanket, with fold to the head, over all
- {i} Place wool blanket between halves of sheet, wide hem at top. Leave enough of the sheet at top to permit folding under a cuff of about 2 inches
- {j} Lay wool blanket, in sheet cover, over cotton blanket. Tuck in foot of blanket

d. Handwashing in the home

(1) General considerations

- {a} Thorough handwashing should be demonstrated and encouraged
 - 1) Before handling infant or equipment used in his care
 - 2) Before and after diapering infant
 - 3) Before and after feeding the infant
 - 4) Before and after bathing the infant
 - 5) Before preparing feedings or putting nipples on a bottle
 - 6) Before and after manual expression of breast milk
 - 7) Before sterilizing or handling breast milk
 - 8) After using a handkerchief or tissue
 - 9) After scrubbing or cleaning
- {b} Diapering and feeding must be considered as two separate procedures with thorough handwashing before and after each procedure
- {c} The upper part of the infant should be considered clean and the lower part contaminated
- {d} Always wash the hands before transfer of care from the lower to upper part of the infant, and from the lower part of the bed to the upper part

(2) Procedure for hand washing

(a) Equipment needed

- 1) Bar of mild soap
- 2) Cup and saucer (soap to be placed on saucer and covered with cup)
- 3) Wash basin or other large container to catch waste water
- 4) Pitcher or other container of warm water, if running water is not available
- 5) Squares of newspaper with which to hold pitcher, or turn on faucets if nurse or attendant is alone
- 6) Clean diaper for towel, hung on nail between two clean newspapers convenient to set-up
- 7) Apron between folded newspapers
- 8) Supply of clean newspapers

(b) Procedure

- 1) Place newspapers on table near working area
- 2) Place apron in a folded newspaper on covered area of table
- 3) Place soap, on saucer covered with cup, on the table
- 4) Put wash basin and a pitcher of warm water on covered table
- 5) Hang a clean diaper for towel on nail on wall between newspapers, same diaper may be used all day
- 6) Remove cup from saucer, pick up soap, have someone pour water over hands or, if alone, handle faucets or pitcher with newspaper squares. Use adequate soap and water. Make a good lather covering up to elbows
- 7) Rinse soap before returning to saucer
- 8) Clean soiled fingernails with clean toothpick
- 9) Rub well, between fingers, over hands and up arms to elbows
- 10) Rinse well, have someone pour water over hands and arms or handle pitcher with newspaper squares
- 11) Repeat procedure second time
- 12) Dry well with clean diaper
- 13) Hang diaper between newspapers
- 14) Put on apron
- 15) After care of infant has been completed, wash hands as above. Empty waste, wash basin with soap and water, and return to a clean set-up on the table. Place pitcher in bowl. Cover soap with the cup. If newspapers covering the diaper are soiled or torn, change at this time. Put apron in folded newspaper and return to set-up

e. Dressing the premature infant

- (1) If the room temperature is low, put the baby in the incubator, without further handling. Protect the linen in the incubator by using a clean diaper for protection. When the incubator is warm, dress the infant in premature clothing

(2) In cool weather use both inside wool shirt and outside cotton flannel shirt. In warm weather use only outside, open-sleeved shirt, use both shirts in event infant weighs less than $3\frac{1}{2}$ pounds

(a) Put cotton shirt outside closed sleeve wool shirt
(b) Hold the baby's arm supporting the elbow with one hand, work the sleeve on as you would a finger into a glove. Be certain infant's fingertips come to the end of the sleeve. Bring shirt well up on the shoulders

(c) Turn baby over and pull shirts well together at the back. Place one finger in the neck band to allow room, place the small safety pin crosswise about one inch down from the neck. Pin crosswise through all the thicknesses. For diagram see Hess and Lundeen, The Premature Infant, first edition, page 272, or second edition page 76.

(d) Take infant's temperature
1) To take temperature by rectum, shake thermometer to 94° and lubricate bulb with vaseline. Insert about one half inch and hold in place for three minutes

2) To take temperature by axilla, hold thermometer in place for at least five minutes or until mercury stops rising. Use suggested bag technique for cleansing thermometer

(e) Pin triangular diaper on high, just under the armpits and over the shirts. Pull shirts well down over the baby's chest and back, not over buttocks. Bring right side of diaper over, then left. Place finger of left hand under top of diaper, pull up bottom flaps of diaper, and fasten with one safety pin. Put pin in vertically with the point upward. Wrap loose flap over the pin and tuck in to prevent the pin from opening

(f) Wrap the baby's body from the waist down, enveloping his feet with the "warming" diaper

(g) Lay blankets well over the baby's chest
1) Always put blankets over the baby. Do not wrap baby in them. Do not tuck them in tightly at side as this interferes with respirations

(h) Place diaper pack in a paper, at foot of bed by heating unit (see diaper pack)

(i) If infant's temperature fluctuates too high or too low a range readjust the thermostat

(j) The glass top may be removed and placed in carrying box during summer use. The top of the incubator should be covered with a mosquito bar netting when glass top is not being used

f. Diapering the premature infant

(1) Equipment needed

(a) Baby's tray

1) Cotton balls in jar

2) Warm water in bowl

- 3) Newspaper bag for waste
 - (b) Diaper pack, in newspaper bag next to heating unit
 - 1) Clean, warm folded diaper
 - 2) Folded warming diaper
 - 3) Quilted pad to cover rubber sheet
 - (c) Two sheets of newspaper
 - (d) Hand washing equipment, if faucet water is not available
- (2) Procedure
- (a) Wash hands and arms under running water and put on clean apron
 - (b) Remove top from jar of cotton. Fill small bowl with warm water. Place newspaper on lower top of Incubator, for clean diaper pack and on floor, for soiled diaper
 - (c) Separate glass on incubator in the middle and inspect feeding towel for vomitus. If dry, fold and tuck in at head of bed. Lift baby's head and turn towel under head to check for dryness, change if damp. Remove diaper pack and place on newspaper on top of foot end glass of incubator
 - (d) Turn upper fold of cover back on itself and roll to foot of bed. Roll cotton blanket to foot
 - (e) Remove warming diaper. Place on newspaper on floor
 - (f) Remove diaper pin and fasten it at foot of bed and remove soiled diaper
 - (g) If infant has had a stool, leave diaper in place and moisten cotton in warm water, oil may be preferable to water in removing meconium. Cleanse buttocks, gently wiping towards rectum. Make certain all feces is cleansed from the groin. Place soiled cotton in newspaper bag
- Note:
- The consistency of the stool from the premature baby is very important. Most premature babies have four to six bowel movements a day, which are small and pasty. If the baby has frequent movements, more than six a day or loose movements, even if not frequent or if a bowel movement contains blood, the doctor should be notified at once
- (h) Leave small rubber square at foot of bed. Take soiled diapers in one hand, cover baby with small cotton blanket with other hand, and place soiled diapers on newspaper on floor. Carry soiled diaper in newspaper to covered diaper container
 - (i) Wash hands and arms under running water when baby has had a stool. If baby has not had a stool, he may be diapered before removing soiled diaper to covered container
 - (j) Open diaper pack, from foot of bed, slip rubber square between folded quilted pad, place triangularly folded diaper on quilted pad.

- (k) Holding pad and diaper in right hand, lift lower part of body by grasping knee with left hand. Place pad and diaper under baby's buttocks. Pull shirt down, bring side of diaper on attendant's right side across baby's abdomen, then left. Place finger of left hand under top of diaper, pull up bottom flaps of diaper, and fasten with one safety pin. Place pin in vertical position with point upward. Wrap loose flap over pin and tuck in to prevent the pin from opening
- (l) Wrap warming diaper over lower extremities enveloping the baby's feet and legs.
- (m) Cover baby with cotton blanket. Replace top covers. Cover infant's shoulders
- (n) Wash hands under running water
- (o) Make up clean diaper pack and place by heating unit
- (p) Close incubator
- (q) Replace top of cotton jar
- (r) Burn paper bag of waste. Wash bowl with soap and water and return to tray
- (s) Wash hands

g. Diaper care

- (1) Supplies which you need for diaper care
 - (a) Covered rustproof pail, for soaking soiled diapers
 - (b) Washtub or washing machine
 - (c) Washboard
 - (d) Mild soap, such as: Ivory, Swan, Lux, Dreft, or Vel
 - (e) Hot water
 - (f) Washing borax
- (2) How to launder diapers
 - (a) To each 2 quarts of cold water in your half filled pail add 1 tablespoon of washing borax
 - (b) Rinse stool from soiled diaper when you take it off
 - (c) Place wet and rinsed diapers in the pail of solution
 - (d) Each day dissolve mild soap in hot water and wash diapers
 - (e) Rinse 4 times, or until water is clear
 - (f) Dry in sun
 - (g) Fold diapers ready for use and place in a clean convenient box or drawer
 - (h) IF YOUR BABY HAS DIARRHEA, OR DIAPERS CANNOT BE DRIED IN SUN, BOIL DIAPERS FOR 10 to 20 MINUTES AFTER WASHING
- (3) Use of Chlorox
 - (a) The use of Chlorox is not advised because baby's tender skin may be irritated by bleaching solution. Never use Chlorox during cloudy or damp weather
- (4) If you consider Chlorox necessary
 - (a) Use 1 tablespoon of Chlorox to each gallon of water
 - (b) Rinse diapers 6 times in clear water
 - (c) Dry in sun

h. Bathing the premature infant

(1) Tub bath

(a) Equipment needed

- 1) Individual basin large enough to permit easy motion and complete submerging of infant's body in the water
- 2) Jar of sterile cotton balls
- 3) Jar of sterile toothpick swabs
- 4) Bottle of soap solution (made from pure mild soap such as Ivory)
- 5) Bottles of rubbing alcohol 40 - 50%
- 6) Jar of boiled water
- 7) Bottle of mineral oil
- 8) Towel (feeding towel)
- 9) Washcloth
- 10) White blanket
- 11) Newspaper pad
- 12) Newspaper bag for waste
- 13) Apron
- 14) Clean diaper

(b) Tub bath procedure

- 1) See that all doors and windows are closed. Room temperature at least 80°
- 2) Select most convenient place for set-up. A table near the stove, with the best possible light, is usually preferred
- 3) Protect table with newspapers
- 4) Spread newspaper by incubator for soiled diapers
- 5) Wash hands and arms
- 6) Put on apron
- 7) Place newspaper pad, bath tray and wash basin on table
- 8) Open newspaper pad on table and cover with clean diaper
- 9) Remove jar covers and bottle tops on tray
- 10) Fill basin with water 105° - 110°
- 11) Wash hands and arms
- 12) Open incubator
- 13) Place feeding towel at upper far side of bed
- 14) Turn down top covers separately folding the upper edge of outside sheet under
- 15) Remove baby's diaper and take the baby's temperature. If baby has had stool, wash buttocks with cotton and warm water. Discard diaper and wash hands
- 16) Cover baby with feeding towel and white blanket
- 17) Turn baby slightly to unpin the shirt, fasten pin at head of bed. Remove shirt and place at foot of bed on top covers
- 18) Pick up baby, hold one hand under shoulders and head and grasp feet with the other hand. Hold baby away from apron. Place baby on pad
- 19) Hold baby's head securely in left hand, wash
- 20) Inspect mouth - do not clean it. Report any white spots to doctor
- 21) Observe eyes. If the eyes are clean do not wash.

- Cleanse discharging eyes with sterile water. When cleansing right eye, turn head well to the right, for left eye turn head well to the left. Cleanse from inner canthus outwards
- 22) Observe nose. If nostrils are clean, they are left alone. To cleanse nostrils, moisten cotton swab in warm water, remove cotton from swab and cleanse with cotton
 - 23) Clean external ear with moistened cotton toothpick swabs. Avoid getting water in ear canal. Carefully inspect area behind ear for excoriation. This area can easily become excoriated unless watched, due to the fact that the external ear has little cartilage and is close to the head.
 - 24) Moisten washcloth and apply soap to make a good lather. Apply to baby's hair. Wrap baby in white blanket, support head and shoulders well. With left hand hold baby's head over basin and rinse off soap. Use care and keep all water out of the ear canal. Dry hair thoroughly
 - 25) Soap washcloth well. Remove drying towel and blanket. Quickly soap chest, arms and abdomen, then turn baby over and soap back as far as the buttocks. Again turn baby over and soap extremities. Soap large pledget of cotton and soap genitalia and buttocks. Do not contaminate your fingers. Discard cotton pad
 - 26) Submerge infant, keeping head well out of water, using washcloth for rinsing. Rinse chest, arms and abdomen, then back and extremities and genitalia last.
 - 27) Dry baby gently. Dry chest, arms and abdomen. Apply 40 to 50 per cent alcohol, at room temperature. Inspect axillary region
 - 28) Turn baby on abdomen and dry back. Apply alcohol.
 - 29) Again turn baby. Cover upper part of baby with blanket. Be certain that the lower part of blanket does not touch the face
 - 30) Dry extremities. Apply alcohol
 - 31) Cleanse genitals with washcloth. In the female infant, it may be necessary to apply mineral oil between the labia minora and labia majora to remove smegma. Oil is applied with a toothpick swab. In the male baby, do not push back foreskin. Dilatation may be necessary, but this is done by the doctor
 - 32) Wash hands and arms. Return the baby to its crib and dress. If possible, have someone else make the bed while the infant is being bathed. Check incubator. If infant's temperature is under 98° close glass top

(c) Care of equipment after bathing

- 1) Empty bath water, wash basin with soap and water and place upside down in clean place reserved for baby's supplies
- 2) Boil washcloth, dry, and place with clean equipment
- 3) Clean tray and tops of separate jars with alcohol and replace on tray
- 4) Hang newspaper pad in suitable place to dry
- 5) Fold dry newspaper pad to inside and place with baby's clean supplies

(2) Sponge bath

Give sponge bath if the baby's cord is on, or when navel is still moist. Procedure follows that of tub bath. Water temperature about 105° - 110° F. Each part of the baby is washed and dried with the baby covered with towel and blanket at all times.

(a) Baby should be bathed in the following order

- 1) Face, head, eyes, nose and ears, as in tub bath
- 2) Soap, rinse, dry, and alcohol chest and arms
- 3) Turn baby over, soap, rinse, dry and alcohol back
- 4) Turn baby over, soap, rinse, dry, and alcohol lower abdomen, thighs and legs
- 5) Soap genitalia and buttocks, rinse and dry
- 6) If band is soiled, wash hands and uncover baby, remove soiled band and dressing and put on clean dressing and band
 - a) Cord dressing which adheres should be soaked loose with sterile water
 - b) If navel, after cord comes off, is moist or bleeding apply alcohol. Clean dressing and band should be used until navel is dry

i. Feeding the premature infant

(1) General considerations

(a) Safeguard cleanliness

- 1) Wash hands thoroughly
 - a) Before handling feeding equipment
 - b) Before preparing breast for feeding
 - c) Before preparing formula
 - d) Before feeding the baby
 - e) Before touching baby's face
- 2) Thoroughly cleanse and sterilize all feeding equipment after each use
- 3) Put only sterilized items in the baby's mouth

(b) Adjustment of individual feeding

- 1) Adapt feeding in accordance with infants
 - a) Age
 - b) Weight
 - c) Sucking ability
- 2) Give feeding slowly to facilitate infant's swallowing
- 3) Hospitalize when infant cannot take maintenance amounts of fluid by 3rd day
- 4) Divide feeding, wait 5 to 10 minutes between each half when baby is

- a) Too apathetic to suck or swallow
 - b) regurgitating or vomiting feeding
 - 5) Keep feeding warm, not hot or cold, but a little more than lukewarm
 - a) Too cool a feeding creates a tendency to vomit
 - b) Too cool a feeding causes premature to be reluctant to eat
 - c) Too hot a feeding may burn his mouth and tongue
 - 6) Establish and follow a routine feeding technique to meet the needs of the individual baby
 - 7) Observe and report at once any difficulty noted during feeding, as
 - a) Inability to swallow
 - b) Cyanosis
 - c) Refusal to suck (provided essential procedures have been followed)
 - 8) Plan procedure so as to promote minimum handling of baby, as
 - a) Bubble after dropper and small bottle feeding by putting baby in a sitting position in incubator, thus eliminating necessity of removing him from incubator
 - b) Feed carefully, and quickly as possible, so as to avoid over-exertion
 - c) Do not exhaust infant by continuing any manipulation necessary to induce sucking or swallowing for too long a time
 - 9) Over-feeding should be avoided
 - a) The tendency to over-feed is one important factor in the mortality and morbidity among prematures in the first 3-6 weeks of life
 - b) Feeding very small quantities of food and increasing the amount slowly establishes the essential "food tolerance" in the premature
 - c) The infant does best if fed the smallest amount of food on which it will gain weight. Prematures will lose weight the first 5 to 7 days
 - d) The advantages of minimum feeding are
 - (1 Prevention of abdominal distention with resulting dyspnea and cyanosis
 - (2 Decreases tendency to develop diarrhea
 - (3 Decreases tendency to vomit and aspirate
 - (4 Brings about a more consistent weight gain
 - 10) Establish an approved method of daily care of equipment and care after each feeding. Replace any equipment which has become worn with use, chipped or broken
 - 11) Establish home record for feeding to show
 - a) Frequency of feeding
 - b) Amount
 - c) All regurgitation
- (2) Schedule, kind, and method of feeding

- (a) Schedule and kind of feeding
 - 1) Follow orders as written or approved by attending physician, or until physician's orders can be obtained, use those suggested in this manual
 - 2) Basis of feeding suggestions
 - a) Feedings have been calculated on a caloric basis of 40 calories per kilogram (2.2 lbs.) body weight for weight maintenance, and 55 calories per kilogram for weight gaining
 - b) Fluid requirements have been calculated at $1\frac{1}{2}$ ounces per pound, a vigorous infant can take up to $2\frac{1}{2}$ ounces per pound
- (b) Method of feeding
 - 1) Selection of method is determined by the stamina and strength of infant
 - 2) Gavage feeding must be given by a trained professional attendant
- (3) Procedure of feeding
 - (a) Equipment needed
 - 1) Determined by type of feeding being given
 - (b) Medicine dropper feeding
 - 1) Place newspaper on lower half of incubator
 - 2) Place newspaper bag on tray
 - 3) Wash hands and put on apron
 - 4) Remove sterile medicine glass from icebox jar with sterile forceps
 - 5) Pour amount to be fed in glass
 - 6) Pour hot water in enamel bowl and place medicine glass containing feeding in bowl
 - 7) Remove medicine dropper from ice box jar with sterile forceps and place in feeding
 - 8) Cover feeding with steri-pad
 - 9) Place cover back on ice box jar
 - 10) When feeding is warm, take to incubator and place feeding on newspaper, covering lower half of glass
 - 11) Push head glass away from the middle towards the head end of incubator sufficiently to permit easy handling of infant
 - 12) Place feeding towel under baby's chin. Be careful to place clean side of towel next to his face, not the side which has touched the incubator
 - 13) Remove steri-pad from feeding and test feeding on inside of wrist
 - 14) Place left hand under baby's shoulders. Place two lower fingers under shoulders, two upper fingers support the back of the head. Elevate baby's head about four inches off mattress, holding him in a comfortable position for him to nurse
 - 15) With your thumb on baby's chin, pull down gently and open his mouth

- 16) Inspect mouth to be certain tongue is down from roof of mouth. The tongue of the premature has a tendency to adhere to the roof of the mouth. Letting the baby's mouth close and pulling down on his chin again, gently but firmly, will usually cause his tongue to drop
- 17) Take dropper in right hand, holding it between thumb and index finger with rubber bulb extending about halfway back of index finger. This helps regulate the flow of the milk, prevents squeezing of the bulb, and aids in making it possible to exert correct pressure with rubber tip on back of tongue, when necessary
- 18) After dropperful has been taken, inspect the back of the throat to make sure that all of the feeding has been swallowed
 - a) To encourage baby to swallow feeding
 - (1 Press firmly on the back of his tongue with the tip of the dropper
 - (2 Gently pinch the back of his neck
 - (3 Make a rotary motion on the jaws with the right hand and thumb
 - (4 Open and close the baby's mouth a time or two by gentle pressure on his chin
 - b) If infant refuses to swallow feeding or acts exhausted after one or two attempts to make him swallow, aspirate the milk from his mouth with the empty medicine dropper. Never offer another dropper of feeding while there is milk in the back of his mouth
- 19) When milk is swallowed continue to offer a dropperful at a time until half of the feeding is taken
- 20) Lay baby's head down and turn face to right side to prevent aspiration in case of regurgitation or vomiting, tuck feeding towel under baby's chin so that his shirt will not be soiled if he does regurgitate
- 21) Cover feeding with steri-pad and close incubator
- 22) Put hot water in enamel bowl, to keep feeding warm
- 23) Wait 5 to 10 minutes before offering balance of feeding
- 24) Test feeding. Add hot water, if necessary, and give baby second half of feeding in the same manner
- 25) When feeding has been completed, place baby's head on right side with feeding towel under chin
- 26) It is not necessary to feed glucose or water in halves. Turn baby's head on left side after giving water
- 27) Cleanse equipment with soap and water, rinse well, and sterilize

- a) In cleansing dropper take it apart, or if the rubber tubing clings tightly to the dropper tip, push it up sufficiently to make certain that the dropper tip is intact
 - b) In replacing the rubber tubing, slide it well up over the tip of the dropper. Allow $1/8"$ to $1/4"$ to extend from end. It must be put high on the dropper or the baby will suck it off, but a little must be left at the end so that the baby's mouth is protected and so that he will have something soft on which to learn to suck
 - c) Boil all equipment except nipples in a covered container for 10 minutes (15 minutes for high altitude)
 - d) Place clean nipples in boiling water for 4 minutes
 - e) Place sterile equipment back in sterile icebox pan with sterile forceps
- (c) Small bottle feeding
- 1) A medicine dropper bulb is the nipple. To make the proper sized hole, thrust a red hot #9 sewing needle, placed in rubber end of pencil, in the center of the nipple. One hole is adequate. You should be able to see through the hole, and fluid should drop and not run through the hole if it is the correct size
 - a) Prepare for feeding as in dropper feeding procedure
 - b) Remove small bottle and medicine glass from covered pan
 - c) Pour feeding into bottle using medicine glass to measure amount of feeding to be given
 - d) Place sterile nipple on bottle and cover with glass bottle cover or steri-pad
 - e) Cover icebox pan
 - f) Place feeding in hot water in enamel bowl
 - g) Test feeding and when warm, carry feeding in bowl and place on newspaper on lower half of incubator top
 - h) Elevate baby's head as when feeding by medicine dropper. Open mouth by thumb pressure on chin
 - i) Place nipple on top of baby's tongue, well back so that it fits in the natural groove made by the baby's tongue when he sucks
 - j) If baby does not start to suck or if he stops frequently, press down on tongue with nipple
 - k) If baby stops sucking because the nipple has collapsed, make sure that it is far enough down on the neck of the bottle and release it a bit to allow more air in the bottle
 - l) If baby takes his feeding slowly, it may be necessary to feed him in portions or at least to reheat the feeding so that it does not become cool

- m) When feeding has been taken, the baby may be bubbled by raising him to a sitting position, then support him across the chest with one hand and pat him gently on the back with the other hand
- n) Cleanse equipment with soap and water, rinse well and sterilize
 - (1. Boil glassware 10 minutes (15 minutes for high altitude)
 - (2. Boil nipples 4 minutes)
- (d) Large bottle feeding
 - 1) Technique and procedure is same as with other two types of feeding except that baby may be picked up to bubble
 - a) Place small folded sheet with wide hem over shoulder and closed edge toward neck
 - b) Place baby over shoulder, support and gently pat back
 - c) Turn baby's head away from attendant's face
- (e) Suggested formula mixtures

Note:

All 5% glucose solution should be made in the home by adding 1 level teaspoon of either Karo or cane sugar to 3 ounces of sterile solution

 - 1) 5% glucose solution of pasteurized milk, half of cream removed
 - 2) 5% glucose solution of milk made of equal parts
 - a) Half and half evaporated milk and sterile water
 - b) Powdered skimmed milk mixture
- (f) Preparing the evaporated milk formula
 - 1) Individual feedings prepared just before use are the simplest
 - 2) Use of small cans of milk is advisable when preparing small quantities of feedings
 - 3) Wipe the top of a can of evaporated milk with a clean, damp cloth
 - 4) Pour boiling water over top of milk can
 - 5) Punch two holes in the top of the can with a clean can opener
 - 6) Pour the required amount of milk directly from the can into a boiled medicine glass, for measurement
 - 7) Add required amount of freshly boiled water or glucose solution
 - 8) Cover opened can with a clean cup, a clean cloth, or wax paper
 - 9) Keep in a cool place until ready to mix the next feeding
- (g) Suggested Feeding Schedule for a vigorous 3 pound premature infant
 - 1) This suggested feeding schedule for a 3 pound infant may serve as a guide for premature feeding. All feedings should be individualized to meet the needs of the infant being fed

SCHEDULE

Age of Prema- ture	Amount of Formula Mixture each Feeding	Amount 5% Glucose (Cane sugar or (Karo) Each Feeding	Number of Feedings	Total Amount
1st 12 hours	NOTHING BY MOUTH			
12 to 24 hours		8 cc.	q 3 h x 4	32 cc. (1 oz.)
Second Day				
1st 12 hours	4 cc.	8 cc.	q 3 h x 4	48 cc. (1½ oz.)
2nd 12 hours	8 cc.	8 cc.	q 3 h x 4	64 cc. (2 oz.)
3rd day	12 cc.	water 8 cc.	q 3 h x 8	160 cc. (5¼ oz.)
4th day	14 cc.	water 8 cc.	q 3 h x 8	176 cc. (6 oz.)
5th day	16 cc.	water 8 cc.	q 3 h x 8	192 cc. (6½ oz.)
6th day	20 cc.	water 5 cc.	q 3 h x 8	200 cc. (6 2/3 oz.)
7th day	25 cc.	water 5 cc.	q 3 h x 8	240 cc. (8 oz.)
8th day	30 cc.	none	q 3 h x 8	240 cc. (8 oz.)
9th day and thereafter	75 cc. (2½ oz. per pound of body weight)		q 3 h x 8	

2) Considerations for individualizing the feeding formula

- With baby who takes feeding poorly, take two weeks instead of eight days to reach 2½ ounces of feeding per pound of body weight
- Baby whose weight is under 3 pounds requires smaller ratio of formula than the ratio of the infants weight to 3 pounds
(1. That is if weight is 2 pounds use a little less than 2/3 of the amount of feeding suggested
- Baby whose weight is more than 3 pounds requires a slightly larger amount of fluid (5% glucose or water) than ratio of infant's weight to 4 pounds
(1. That is 1 1/3 times suggested amount

(h) Suggested vitamins for premature infant

VITAMIN	Preparation	Age to Begin	Amount	Changes	Method of Administration
K	Such as Hykinone	All prematures under 4 days of age	2 mg.	If first dose given 1st or 2nd day repeat next day	Intra-muscularly
C	Ascorbic acid (Calcium ascorbate less irritating) NOTE: Special parenteral preparation of calcium ascorbate to be used when oral use is not well tolerated.	24 hrs.	100 mg.	After 3 or 4 days increase to 50 mg.	Orally
A & D	Percomorph oil or Homicebrin	2 weeks 1 week	5 gtts. 4 x d. 1 teas- poon	After 5 days if tolerated 10 gtts. 3 x d. continue	Drop directly into mouth Orally
B Complex	Brewer's yeast	10 days	$\frac{1}{4}$ teas- poon per feeding	q. 2 d's $\frac{1}{4}$ teas- poon to 1 additional feeding until 2 teaspoons are given q. d.	Orally
Iron	Ferrous Ammonium Citrate	2 - 3 months	1 grain 2 x d.	If no gastro-intestinal upset increase to 3 grain 3 x d.	Between feed- ing in sterile water Orally

(1) Breast feeding

The premature who nurses well from a full sized nipple and bottle, may be put to breast on doctor's order

1) General considerations

- a) For the first few days allow infant only 10 minutes and for one or two feedings only

- (1. Offer complementary feeding after nursing period
 - (2. Gradually increase number of times infant is put to breast and length of time at breast
 - (3. Express remaining milk from breast after infant has nursed
 - (4. As baby becomes stronger, in order to stimulate the formation of breast milk and to eliminate complementary feeding, if necessary, the baby may nurse one breast 15 minutes and the other 5 minutes. Alternate breast nursing at next feeding
 - (5. Routine breast care is acceptable
- 2) Manual expression of breast milk
- a) Importance of maintaining breast milk
 - (1. Every effort should be made to maintain the mother's milk supply and to have the infant nurse as soon as he is physically able. Formula mixture is considered the feeding of choice until infant is strong enough to be put to breast. See: Feeding of Premature Infants, by Harry H. Gorden, M.D., Denver, reprinted from American Journal Diseases of Children June, 1947, Vol. 73, pp. 713 - 718
 - b) Teaching of procedure
 - (1. Review anatomy of breast
 - (2. Suggestions to help maintain milk supply
 - (a. Express milk 4 - 5 times daily at regular intervals
 - (b. Empty breasts each time
 - (c. Eat a well balanced diet (use MCH - 18 Form, "Foods needed during Pregnancy and While Breast Feeding the Baby," as a teaching guide)
 - (d. Observe daily rest periods
- 3) Method
- a) Sterilize cup covered with steri-pad
 - b) Get pan of warm water, mild soap, washcloth, and towel, to be used for this purpose only
 - c) Have mother sit in comfortable position with the best possible light
 - d) Wash the breast well with soap and water, and cleanse with cotton pledget dipped in sterile water
 - e) Grasp the breast with thumb and index finger about $1\frac{1}{2}$ " from the end of the nipple at the edge of the areola. This makes it possible for the pressure to be behind the milk wells
 - f) With a scissors like motion made with the thumb and index finger, the milk is expressed in a stream

- (1. The beginner will make 40 to 50 motions per minute
 - (2. The experienced person will make 60 to 100 motions per minute
 - g) Cleanse and dry the breast
 - h) Discard breast milk
 - i) Clean equipment
 - (j) The immediate care of cyanotic infant
 - 1) Inspect throat for mucous and fluid
 - a) Methods of removal
 - (1. Gently swab throat with long cotton applicator covered with gauze
 - (2. A sterile #10 or #11 catheter with glass mucous trap attached may be inserted to the posterior pharynx of the baby
 - (a. Gently milking the trachea upward will help bring mucous and fluid into the posterior pharynx for aspiration by the catheter
 - 2) Aromatic spirits of ammonia may be used as suggested
 - 3) Employ the postural drainage, that is, lower the head of the mattress and raise the foot of it
 - 4) Oxygen should be given when available
 - 5) Abdominal distention should be relieved
 - a) Permit baby to belch
 - b) Feeding should be discontinued until gastric and intestinal distention is relieved
 - c) Correction of dietetic error is essential
 - d) Check time of infant's last stool
 - (1. If no stool within 24 to 36 hours, instigate therapy to evacuate bowels. See Hess and Lundeen, The Premature Infant, first edition pp. 202-203, and second edition pp. 260-261)
- k. The use of portable incubator equipped with oxygen
NO SMOKING or open flames while oxygen is turned on
 - (1) Purpose
 - (a) To furnish warmth and safety for the premature infant while in transit from the home to a care center
 - (b) To provide a method of furnishing oxygen
 - (2) Procedure
 - (a) When carrying case is requested, place filled hot water bottles in carrying case and check to be certain equipment is ready for use
 - 1.) Inside of incubator washed with soap and water, since last use
 - 2.) Outside of carrying case dusted
 - 3.) Lining for case and clothing for transportation
 - a.) Cord dressing
 - b.) Gauze band
 - c.) Diaper
 - d.) Two flannel blankets, one for mattress

- e.) Flannel hood, double thickness*
- 4.) Funnel for oxygen administration, clean and in paper bag
- (b) Take incubator to home
- (c) Check condition of infant
- (d) Ask responsible person in the home to wash hands and prepare baby for transportation
 - 1.) In hooded wrapper
 - 2.) Diaper under buttocks
 - 3.) Cord dressing if needed
- (e) Check temperature of incubator
- (f) Refill hot water bottles, one at a time, if indicated
 - 1.) Use care to avoid pinching the rubber of the hot water bottle and cause leakage
- (g) Check to be certain the incubator temperature registers 80°
- (h) Fill humidifying bottle two-thirds full of water
- (i) Attach funnel to oxygen tube, inside incubator
- (j) Place folded blanket over bottom of incubator as improvised mattress
- (k) Remove rubber tubing from oxygen tank
- (l) Turn oxygen tank control to right, minimum turn is all that is required
- (m) Note exact time on attached tag
- (n) Connect rubber tubing at oxygen outlet
- (o) Regulate control. Have 100 bubbles per minute in humidifying bottle
- (p) When temperature and oxygen are regulated, request family to place baby in carrying case
- (q) Place oxygen funnel in front of infant's face
- (r) Place second blanket on top of infant, do not wrap
- (s) During transportation observe frequently the following
 - 1.) Condition of infant
 - 2.) Count bubbles of oxygen
 - 3.) Note temperature of incubator
- (t) On arrival, open portable incubator
- (u) Ask attendant to remove infant from carrying incubator
- (v) Turn oxygen off and indicate on the tag the minutes of running time
- (w) Place temporary clothing in incubator
- (x) Return to local Health Department
- (y) Health Department Personnel are responsible for the cleaning of the incubator and clothing

*See: Hess, Julius H., M.D., and Lundeen, Evelyn C., RN., The Premature Infant Medical and Nursing Care, Second edition, Philadelphia, J.B. Lippincott Company, p. 73; or first edition, p.68.

- 1.) Wash incubator with soap and water, inside and outside
 - 2.) Remove and wash oxygen funnel. Either boil in "jumping water" for 4 minutes or autoclave
 - 3.) Empty water in humidifying bottle
 - 4.) Empty hot water bottles, and inflate
 - 5.) Wash all clothing and lining of carrying case
 - 6.) Autoclave, if not possible, boil clothing and lining
 - 7.) Protect equipment by placing in paper bag in a clean carrying incubator
 - 8.) Check oxygen control to be certain it is closed
- Note: Local Health Department is responsible for furnishing lining, and clothing for carrying case

1. Suggested form

- (1) Referral card from hospital to local health department

Hospital _____ Date _____

A premature baby weighing _____ pounds was born

on _____ to Mrs. _____

Address _____

Is to be discharged from hospital on or about _____

Attending Physician _____ Address _____

- (2) Summary report sheet from Local Health Department to Hospital

Date _____

A visit was made to the home of baby _____

Premature patient of Dr. _____

Preparations ^{{have} (have not been made in the home for the

reception of the baby. They will be completed within

the next _____ days. The mother ^{{is} (is not able to assume

care of the baby. When the baby is discharged, home

visits ^{{will} (will not be made by us to assist the family.

Remarks on home environment and facilities for care:

(Note presence of infection in home, etc.)

6. Midwifery program

- a. Public health nurse's responsibility in the program
 - (1) Each nurse should be familiar with the "Regulations Governing the Practice of Midwifery" as promulgated by the New Mexico State Board of Health, May, 1944
 - (2) The midwife can be helpful to the nurse when a satisfactory relationship has been established between the county health department and the midwives in the area. The midwife is usually a person of importance in her community. She can aid the health program in an area
- b. Bag for midwife
 - (1) Bag contents
 - (a) Each registered midwife who is licensed to practice midwifery by the district health officer will be issued a regulation midwife bag. Instructions regarding care of the bag, and packing of its contents is included in the midwife's instruction
 - All midwife bags are the property of the New Mexico State Department of Public Health. It is to be returned to the county health department when the midwife discontinues practice (retires, moves to another district, state, or dies)
- c. State of New Mexico Regulations governing the practice of midwifery
 - (1) Each midwife's bag will contain a copy of the Regulations governing the practice of midwifery, a signed copy of the Midwife's Pledge, Certificates of Live-birth, and Certificates of Stillbirth (see copies). These are to be kept in a large envelope underneath the bag lining
- d. Supplies
 - (1) The midwife may secure from the county health department the following supplies which are furnished by the State Health Department:
 - (a) Cotton
 - (b) Sterile cord dressings with tape
 - (c) Sterile cord dressings without tape
 - (d) Silver Nitrate capsules - 1%
- e. Reports and forms
 - (1) A supply will be given to each midwife of the following, at the conclusion of classes
 - (a) Cards - No. 1, No. 2 and No. 3
 - (b) Midwife Call for Assistance Forms (English and Spanish)
 - (c) Midwife Annual Report (English and Spanish)
 - (d) Care of the Newborn Baby's Skin (English and Spanish)
 - (e) Care of the Baby During the Winter (English and Spanish)

- (f) One copy of the booklets, "Planning for the Baby", and "Our Baby"

f. Content of classes for midwives

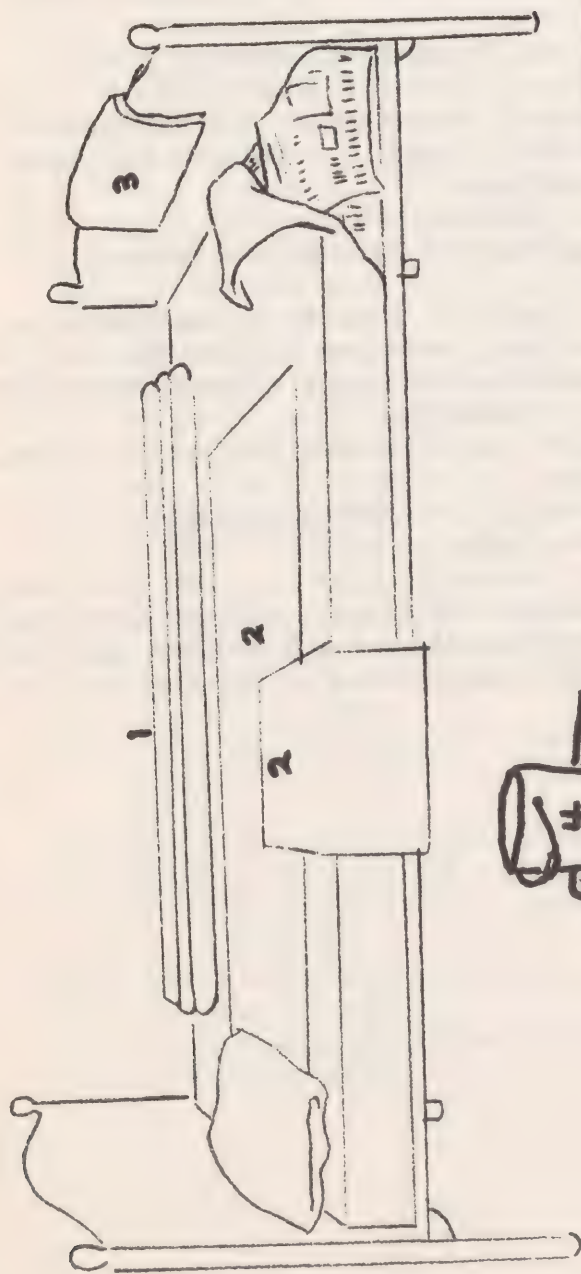
The midwife is trained to deliver normal maternity cases. She is instructed and has learned from her experiences to recognize abnormalities at their beginning. She can obtain medical assistance in the home or transfer the patient to the hospital

- (1) Purpose of classes, regulations governing the practice of midwifery, midwife's pledge, and birth registration
- (2) Elementary anatomy and physiology of the pelvis and breast
- (3) Signs of pregnancy, maternal care during pregnancy, abnormalities and discomforts of pregnancy, how to recognize same, relieve discomforts and value of medical aid for abnormalities
 - (a) When medical assistance is unobtainable the midwife is directed to contact the county health department
- (4) Preparation for home delivery; mother's and baby's supplies (Value of classes for mother and fathers)
 - (a) See diagram for room plan
- (5) Midwife management of the first stage of labor; the midwife's plan for cleanliness of patient, bed, gown or shirt, and midwife may give the patient an enema
 - (a) Observation of lie and presentation of the fetus
- (6) Midwife management of the second stage of labor; immediate care of the newborn baby
 - (a) Midwife washes hands
 - (b) Midwife puts on cap and mask
 - (c) Midwife scrubs hands and forearms for five minutes (Does not dry)
 - (d) Midwife puts on gown, requests assistant to tie gown
 - (e) Assistant to place sheet or light cotton blanket over the patient as directed by midwife
 - (f) Midwife places muslin towel on patients buttocks covering anus
 - (g) As soon as infant's head is delivered, cleanse eyes with clean cotton balls moistened with sterile water
 - (h) When infant is delivered, cord is tied and cut
 - (i) Infant is placed on second muslin towel
 - 1) May then be put in a clean warm receiving blanket
 - (j) Instill silver nitrate in infant's eyes as soon as practical
 - (k) Remove infant from delivery area and place in mother's arms

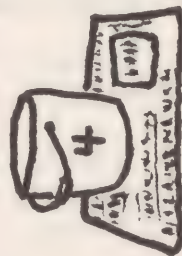
- (7) Midwife management of the third state
 - (a) When placenta is retained for more than two hours, without bleeding, call for medical assistance
 - (b) When placenta is retained with bleeding, call medical assistance, stat.
 - (c) Midwife examines placenta and membranes to be certain that they are intact
- (8) Immediate after care of patient and infant
 - (a) Mother is to be made as clean and comfortable, as possible, and to be carefully checked for uterine bleeding
 - (b) Soiled linens are to be placed in cold water to soak
 - (c) Infant's cord is retied, sterile dressing and band applied
 - (d) Skin is cared for as suggested in New Mexico publication, "Care of Newborn Baby's Skin"
 - (e) Midwife is instructed to examine infant carefully for abnormalities and to report all such to the health department:
 - 1) All crippling conditions
 - 2) All babies weighing $5\frac{1}{2}$ pounds or less
- (9) Postpartal follow-up
 - (a) Midwife reports to public health department on Card No. 1 for nursing service follow-up
 - (b) Midwife is responsible for care of patients for 10 days following delivery
 - 1) Obtaining medical assistance for complicated cases
 - 2) Reporting to county health department
 - a) Red or discharging eyes
 - b) When medical consultation is not available, consulting with the local health department regarding complications of mother and infant
 - (c) Value of well child conference supervision for infant

DIAGRAM OF SET-UP FOR MIDWIFE HOME DELIVERY

BED

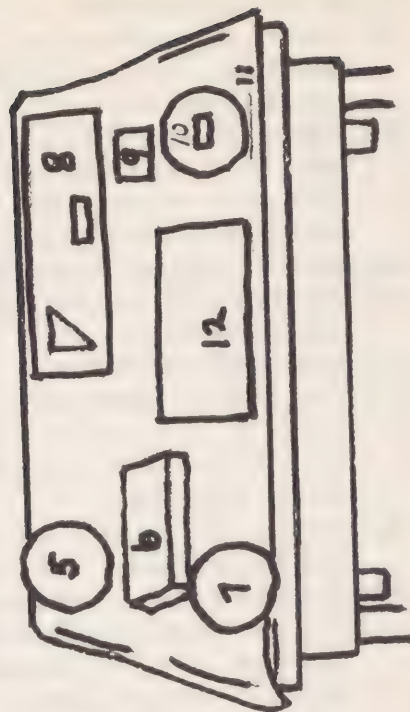


1. Covers rolled back
2. Newspaper pads
3. Sheet or cotton blanket to cover patient during delivery
4. Pail for waste

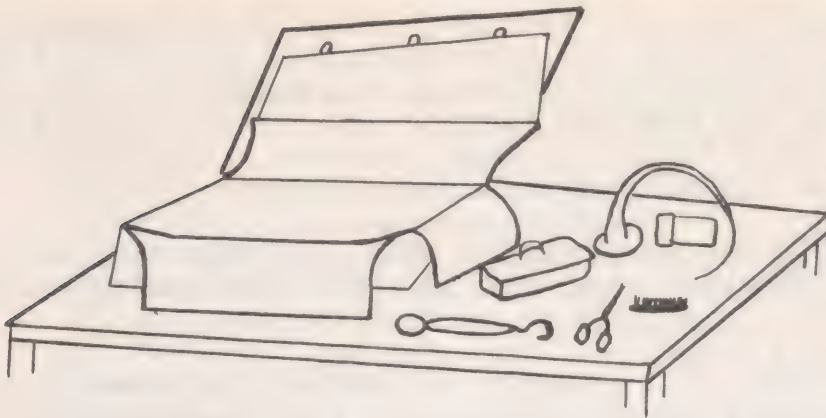


TABLE

5. Cotton balls - boiled
6. Instrument dish - scissors, brush, 12 cotton balls
7. Bowl (cover from cotton balls) containing cool sterile water
8. Gown, cap and mask
9. Cord dressing with tape
10. Soap on saucer
11. Orange wood stick
12. Receiving blanket



STANDARD EQUIPMENT FOR THE MIDWIFE BAG



1. Take everything out of the midwife bag and place on clean table
Never put the bag or any of it's contents on the floor
2. Place large brown envelope in the bottom of the bag. Envelope should contain:
 - Birth Certificates - English and Spanish
 - Copy of Rules Governing the Practice of Midwifery
 - Pledge
 - Forms for sending for medical aid .
3. Place clean, ironed lining in bag, with the long flaps over each side
4. Place two white towels, folded as shown in class, in left hand corner of the bag
5. Place drawstring bag containing funnel and rectal tube in center of bag
6. Place, in front of other bag, second drawstring bag containing:
 - Soap and orange wood stick
 - 1 box of silver nitrate capsules
 - 2 packages of cord dressings with ties
 - 1 package of cord dressings without ties
 - 1 spring baby scale
7. Place midwife gown, folded as shown in class, in left hand corner on top of towels
8. Fold cap and mask and place on top of gown
9. Place, in right hand corner of case, enamel pan containing:
 - 1 pair of scissors
 - 1 hand brush
10. Place 1 box of midwife cotton at side of enamel tray
11. Fold top flaps over case then fold over side flaps
12. Place one folded newspaper on top of bag lining, one hand towel, soap and own apron
13. Place two large sheets of newspaper on top of towel and soap
14. If you are sure that you have packed your bag properly and that nothing is missing, your bag is ready to take out on a call
15. Have everything in your bag when you go on a call
16. Only those things on this list should be put in your bag

E. CHILD HEALTH SERVICE

The public health nurse's responsibility in this phase of family service includes the supervision of the child from birth through adolescence. Care of the newborn is discussed under Maternity and Newborn Service and the school age child is discussed under School Hygiene Service. This section is confined to the infant and preschool child.

The parents will need assistance with the physical and psychological problems that are ever present during these formative years.

Nursing activities in a program for infant and preschool health consist of giving nursing care and teaching parents through individual conferences and group activities. Needs may be discussed when the nurse visits the home or when the parents bring the child to the Well Child Conference.

1. NOPHN suggested functions in the infant and preschool child service
 - a. Assisting in securing complete birth registration
 - b. Assisting in securing medical supervision, dental examinations, and the correction of defects for every child
 - c. Giving or arranging for nursing care for sick children, teaching through demonstration, and supervising care given by relatives and attendants
 - d. Assisting in the control of communicable diseases through teaching the recognition of early symptoms, the importance of isolation and the value of immunization
 - e. Participating in programs for the prevention of handicaps and the care and education of handicapped children
 - f. Assisting the family in carrying out general and specific medical advice concerning feeding, with emphasis on the value of breast feeding
 - g. Assisting the family to carry out general and specific medical advice concerning early child care and training
2. The nurse's responsibilities in the child health service
 - a. For effective service the nurse needs scientific knowledge concerning the following phases of child care
 - (1) Physical care and hygiene of the normal child
 - (2) Mental growth and development
 - (3) Nutrition

- (4) Prevention of disease
- (5) Children's diseases

3. The home visit

- a. Case-finding—an important function in health service. Suggestions to establish and maintain a balanced generalized program
 - (1) Referrals by private physicians
 - (2) Referrals from hospitals
 - (3) Home visits for any other phase of service
 - (4) Contacts with parents in group work
 - (5) Reports of birth registration
 - (6) Reported by neighbors and other patients
 - (7) School visits
 - (8) Reported by members of health council or advisory committee
- b. Visit spacing
It is recommended that visits be planned on the basis of individual needs rather than according to a fixed schedule. Interest and responsiveness of the parents should be considered in making the home visit
- c. Visit content
A visit usually includes
 - (1) Inspection of the child
 - (2) A conference with the mother about his health, development and habits
 - (3) Demonstrations regarding his care

4. Suggestions to the public health nurse

- a. Use available source materials and keep currently informed on the following
 - (1) Procedure of inspection of infant
 - (2) Procedure of inspection of the preschool child
 - (3) Nutrition
 - (4) Physical development
 - (5) Personality development
 - (6) Posture
 - (7) Exercise
 - (8) Elimination
 - (9) Fresh air and sunshine
 - (10) Sex education
 - (11) Constructive discipline
 - (12) Dental care
 - (13) Disease prevention

5. The child health conference

The local medical society should approve the establishment of all local Well Child Conferences. A physician will hold the conferences assisted by the nurse and volunteers. When a physician is not available, the

nurse may conduct nursing conferences. All conferences are more effective when attendance is small and plenty of time is allowed for a thorough examination and consultation with each parent and child. The public health nurse is the keystone of all public health programs; upon her ability, energy, tact and judgement will rest the success or failure of all the objectives of the Well Child Conferences.

a. Conference objectives

- (1) Parental education
- (2) Guiding the parents in the establishment of physical well-being and desirable emotional habits in the child
- (3) A more sound parent-child relationship
- (4) Detect early deviations from normal growth and development, mental and physical and advise the parent as to the need for correction (one of the goals of preventive medicine)
- (5) Provides an educational experience for the nurse and prepares her to do a better teaching job

b. Conference procedure

The minimum conference staff includes the physician, the public health nurse, and one or more volunteers. (See Volunteer Handbook, New Mexico State Department of Public Health). Ideally two nurses are in attendance at the Well Child Conference.

Attendance at the conference is dependent to a large degree on the effectiveness of the nurse's contacts with parents in the home.

QUALITY is of more importance than QUANTITY and this cannot be obtained when the conference is too large. The appointment system limits the attendance to the number that can be given satisfactory service and it is desirable that it be used.

If the nurse is to fulfill the primary educational objectives of the conference, her time should be saved for these professional activities that she alone is qualified to perform. Her time can be better utilized for educational purposes than in taking temperatures and weighing and measuring babies, except where these procedures are used for specific educational purposes such as teaching the mother to observe certain features of normal growth and development. The nurse should teach volunteers to carry out these procedures. (See Volunteer Handbook, New Mexico State Department of Public Health)

(1) Duties of the public health nurse—as the most important services for her to perform are those that contribute most to the educational value of the conference. The nurse's duties in the Well Child Conference may be summarized as follows*

*Childrens Bureau Publication No. 261, "The Child Health Conference"
p. 17-18

- (a) General management of the conference
- (b) Taking part of the histories of newly admitted children
- (c) Conferring with the mother before she sees the physician
- (d) Observing signs of illness of children as they come to the conference and isolating or excluding them as indicated
- (e) Instructing or supervising volunteer aids in the performance of their non-professional duties
- (f) Carrying on individual or group instruction or demonstration of exhibit materials for waiting parents
- (g) Introducing to the physician, the mothers and the children who come to the conference for the first time
- (h) Discussing with the physician any facts related to the progress being made or to home conditions
- (i) Being present, whenever possible, during the physician's conference with the mother
- (j) Conferring with the mother before she leaves the conference concerning the recommendations of the physician, to give her an appointment for her next visit to the conference, to determine whether or not her questions have been satisfactorily answered and, if indicated, to make an opportunity for a home visit
- (k) If indicated, referring patient to other community agencies such as, hospital, clinic, welfare agency, school, or private physician
- (l) Participating in joint conferences of professional staff following the conference to review recommendations and plan jointly for carrying them out
- (m) Seeing that individual service records and activity reports for each conference are complete
- (2) Other conference procedures

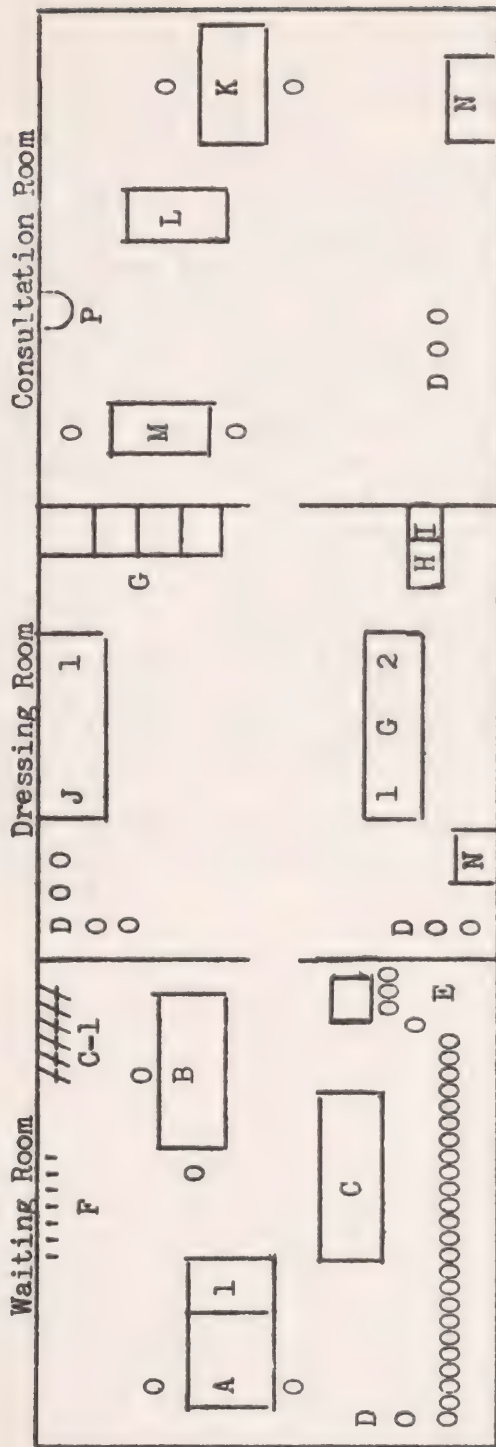
For details, the public health nurse is referred to Children's Bureau Publication No. 261, The Child Health Conference.

6. Conference quarters

The location of the conference quarters is an important item. It is usually the nurse who assumes responsibility for stimulating community awareness and cooperation in providing adequate and comfortable quarters. (See attached diagram)



Desirable Arrangement of Rooms for Child Health Conference



- | | |
|--|--|
| A. Desk for history taking | H. Platform scales |
| 1. File | I. Measuring tape against wall |
| B. Table for nurse's consultation | J. Table |
| C. Table for exhibit material | 1. Thermometer tray |
| 1. Blackboard | K. Examining table |
| D. Chairs | L. Supply table |
| E. Play corner surrounded by chairs facing table | M. Table for immunization supplies and space for "recorder" to sit to take physician's dictation |
| F. Hooks or clothes tree for wraps | N. Supply cabinet |
| G. Tables for undressing and weighing babies | P. Lavatory or hand-washing facilities |
| 1. Scales | |
| 2. Paper or shopping bags | |

F. SCHOOL HYGIENE SERVICE

1. NOPHN suggested functions for the school child

- a. Participating in developing school health education programs based on the needs of the pupils
- b. Assisting physicians in the examination of school children and interpreting findings and recommendations to teachers, parents, and children
- c. Teaching the value of adequate health supervision and helping in the use of health facilities
- d. Assisting in securing correction of defects
- e. Instructing teachers, parents, and pupils to observe and recognize normal health and deviations from it
- f. Assisting in the control of communicable disease through teaching the recognition of early symptoms, the importance of isolation, and the value of immunization
- g. Promoting the maintenance of a physically healthful school environment, including sanitation, seating, lighting, ventilation, school lunches and other physical factors
- h. Promoting the maintenance of an emotionally and socially healthful school environment
- i. Arranging for the care of emergency and minor injuries and illnesses in accordance with medical standing orders
- j. Participating in a program for the prevention of handicaps and the care and education of handicapped children
- k. Coordinating public health nursing activities for school children with all other health forces of school, home, and community
- l. Participating in curriculum making, and giving group instruction in principles of healthful living and home care of the sick

2. Program administration

- a. A school nursing service may function as a specialized service or as a part of the generalized nursing program of the local public health department
- b. Regardless of the type of administration, the superintendent of schools is responsible for all activities carried on within the school, therefore, the nurse secures the approval of the superintendent for all policies and plans for the school health program. The school superintendent is responsible for teacher participation in the health program
- c. The District Health Officer is responsible for all public health activities in his district and hence all plans for community health projects, the control of communicable disease and immunizations are planned with his approval and with the cooperation of his staff
- d. The health program of the school is a cooperative project, in which the superintendent, the principal and classroom teachers, the school nurse, the district health officer and his staff, physical education instructors, school custodians, bus drivers, parents and community health and social agencies, each play an important part

3. Professional guidance and responsibilities

- a. The school nurse observes the rules of professional ethics in working with the medical, dental and nursing professions. She wears a professional uniform, which, in New Mexico is the National Public Health Nurse's uniform. She keeps abreast of the advances in her profession by being a member of the State Nurse's Association and the National Organization for Public Health Nurses, by subscribing to the American Journal of Nursing and the Public Health Nursing magazine. She should be an active member of all professional organizations
- b. The nurse who is giving a specialized school nursing service in the school program and who is not connected with a health department must recognize the need for medical approval of all policies involving nursing procedures and instructions. If there is no school physician, the board of education and the superintendent of schools should formulate and adopt definite policies of administration in cooperation with the district health officer
- c. Most school nurses request professional help and advice, which can only be given by a supervising nurse. The district supervising nurse is always available for this service. In areas where there is no district nursing supervisor, a request may be sent to the Division of Public Health Nursing for assistance. This request must be approved by the district health officer. The consultant will then assist the nurse in program planning, and the interpretation of the policies of the school nursing services to the nursing staff, school personnel and community agencies

4. Program planning

- a. The total program should be planned using the New Mexico School Health Manual for Elementary Teachers, integrating the NOPHN suggested functions for the school child

5. School nursing procedures

- a. As outlined in New Mexico School Health Manual for Elementary Teachers
 - (1) Please note that supplementary standing orders are issued from time to time, such orders must have local medical approval before adoption
- b. See 1949 Revised Suggested First Aid Kit for Bus Drivers

G. ADULT HYGIENE

1. NOPHN suggested functions for adult health supervision

- a. Encouraging periodic health examinations
- b. Teaching the fundamentals of personal hygiene in order to assist in the prevention and retardation of diseases specific to adult life
- c. Assisting in securing early diagnosis and treatment of those diseases

2. NOPHN suggested functions in industrial nursing

- a. Promoting positive health through teaching individuals and groups of workers personal hygiene and the prevention of disease and injuries
- b. Giving or providing for first aid under medical direction, and also for necessary subsequent care to sick or injured employees
- c. Assisting the physician with medical examination of employees
- d. Assisting in securing the correction of defects
- e. Coordinating the health service with the industrial relations program, which may include
 - (1) Assisting the safety department in the interpretation of its program
 - (2) Keeping adequate medical and health records of all cases including compensation cases
 - (3) Offering consultation service to the manager of the lunchroom
 - (4) Interpreting the plant sanitation program to employees
 - (5) Assisting in developing recreational facilities
 - (6) Making available to various departments appropriate data from nursing records
- f. Coordinating the nursing service with the other health and social services in the community through
 - (1) Securing needed health and social service for the industrial worker and his family
 - (2) Developing working relations with the health department and other community agencies and securing their participation in promoting health within the plant

H. MORBIDITY SERVICE

1. NOPHN suggested functions in non-communicable disease

- a. Assisting in securing early medical diagnosis and treatment
- b. Giving or arranging for necessary nursing care, teaching through demonstration, and supervising care given by relatives and attendants
- c. Assisting in arranging for and giving special care to patients with special types of disability such as orthopedic, arthritic, cardiac conditions, diabetes, and cancer
- d. Assisting in planning convalescent care and rehabilitation of the patient
Observing and assisting in adjustment of health situations in the homes of patients; teaching general hygiene and the prevention of disease; and bringing the family in touch with appropriate community health resources

2. Treatments

The principles of good nursing care are to be observed in the general morbidity situation. Finished workmanship and consideration of the patient's emotional and physical comfort are important. A knowledge of the principles involved in specific nursing procedures is pre-supposed. When questions arise, the nurse should consult the attending physician

Treatments are given and dressings changed only when ordered by the physician in charge of the patient

a. Medical orders

- (1) Specific orders to be obtained from the physician.
Specify on nursing notes whether using routine standing orders approved by attending physician, or specific orders
 - (a) Medication - kind, dosage, time to be given, expected therapeutic effect, and possible reaction
 - (b) Dressings - kind, frequency. If physician wishes, submit report regarding character of drainage and/or condition of wound
 - (c) Treatment - methods prescribed by physician, frequency, results to be expected
 - (d) Dates to begin and terminate bedside nursing care

b. Family responsibilities

- (1) Providing necessary supplies and equipment and maintaining equipment
- (2) Assisting the nurse with treatment insofar as is possible for safe techniques and procedures
- (3) Observing the method of treatment
- (4) Demonstrating ability to give treatment in nurse's absence, if possible, ordered by the physician

c. Nurse responsibilities

- (1) Using available family equipment
- (2) Interpreting to the family their responsibility in providing materials and in assisting with the care of the patient
- (3) When ordered by the physician to help the family in assisting themselves
 - (a) When the nurse has taught a member of the family, or person of their choice, the more complicated treatments
- (4) Reporting results of treatment and conditions to physician, use Action Report

d. Procedure techniques

Resourcefulness and ingenuity are constantly required of the nurse who is called upon to adapt her knowledge of nursing procedures to home situations. The following suggestions for adaption of these principles to home practice may be helpful

(1) Enema

- (a) For protection of bed, newspaper pad or plain newspaper covered with clean cloth may be used
- (b) When rubber enema bag is used, make up solution in container and pour solution into enema bag
- (c) Test temperature of solution by pouring on wrist
- (d) Lubricate enema tube with ~~vaseline~~ ^{petroleum jelly} or other lubricant placed on toilet paper
- (e) Fan fold newspaper and place on back rim of the bedpan for comfort. When removing, pull paper down to serve as bedpan cover
- (f) As enema tip is removed place it in folded half of newspaper, held near rectum and carry with bag or can to cleansing area
- (g) Family care of equipment
Teach family to keep equipment as clean as possible at all times; bedpan placed in shopping bag or covered with folded newspaper. If bag and tubing are to be used for other treatments they should be boiled
 - 1) Wash enema tip thoroughly with soap and water
 - 2) Boil three minutes
 - 3) Store with the bag between treatments
- (h) Nurse's care of her own equipment
 - 1) Wash enema tip thoroughly
 - 2) Boil three minutes

(2) Colon irrigation

- (a) Same equipment as for enema with the following additional articles
 - 1) Large pail for return flow
 - 2) Large pitcher, or substitute, for extra solution
 - 3) Extra tube or Y tube
- (b) The nurse should have had experience in giving this treatment or be supervised before attempting to give it in the home. An enema must precede the colon irrigation. The family may be taught, on medical orders, to give the enema before the nurse arrives

- (3) Colostomy irrigation
For protection of bed, use newspaper pad. There are different types of equipment, methods and kinds of solution used. Obtain specific medical orders from the physician in charge, the recommended procedure for the irrigation and protection of the surrounding tissues
- (a) Procedure
 - 1) It is recommended that a soft rubber catheter attached to a small funnel be used for giving the solution
 - 2) A small pitcher or pan can be used for pouring solution
 - 3) An emesis basin held against the patient's abdomen is suitable for catching the return flow
 - 4) Discard contents of emesis basin into a pail at the bedside
 - (b) When patented irrigator is prescribed, follow directions of physician and company
 - (c) Care of equipment: The family should provide a covered pan or kettle in which all the equipment may be washed, boiled and kept in readiness for use
- (4) Vaginal douche
For protection of bed, use newspaper pad under buttocks
- (a) Boil tip before use
 - (b) If sterile douche is given, all equipment including the bag must be boiled
 - (c) The bag may be kept in a freshly ironed pillowcase, towel, or clean paper sack between treatments
- (5) Catheterization*
- (a) Purpose
 - 1) To empty the bladder when patient cannot void
 - 2) To obtain sterile urine specimen for microscopic examination or culture
 - (b) Equipment in the clinic
 - 1) Basin with three cotton pledgets and soap solution (sterile)
 - 2) Sterile water in bottle
 - 3) Sterile rubber catheter #14, #16
 - 4) Sterile specimen bottle and an unsterile waste container
 - 5) Clean towel
 - 6) Two finger cots
 - (c) Procedure in clinic
 - 1) While patient is in lithotomy position, place a folded towel under the buttocks

*From Catholic Maternity Institute, Santa Fe, New Mexico

- 2) Open sterile basin, use wrapper for field cover, put on it two dry sterile cotton balls and a sterile rubber catheter. In the basin, place three cotton balls and add a small amount of sterile soap solution
- 3) Wash hands under running water with soap, put finger cots on thumb and index fingers of left hand and scrub hands well for five minutes with soap and water
- 4) Without drying hands, take one soapy pledget in fingers of right hand. With index and thumb of left hand separate labia and with a single downward stroke cleanse left labia
- 5) Take another soapy pledget, wash down right side
- 6) With the third pledget, cleanse urethra
- 7) Take dry sterile sponge, have assistant (may set up separate basin with sterile water when working alone) pour over it a small amount of sterile water and wipe off area about urethra with a single downward movement
- 8) Grasp rubber catheter with thumb and index finger of right hand about four inches from the end and insert into urinary meatus
- 9) Hold specimen bottle in left hand, fill with urine, pinch off catheter and place the end of it in the waste basin and complete the catheterization
- 10) After the catheter has been withdrawn, wipe the patient dry with the last dry pledget, and make her comfortable
- 11) Close specimen bottle, label with patient's name, address, and the date
- 12) Rinse catheter and place in soiled glove basin
- 13) Take specimen to laboratory
- 14) Record treatment on patient's record giving time and reason for treatment and the amount obtained. Record any unusual symptoms

(d) Equipment in the home

- 1) Basin of boiled cotton and water
- 2) Sterile catheter
- 3) Sterile specimen bottle (when necessary), and waste container
- 4) Clean, folded towel or diaper
- 5) Three dry pieces of cotton
- 6) Paper bag
- 7) Newspaper

(e) Procedure in the home

- 1) Explain the treatment to the patient in order to secure her cooperation and allay fear
- 2) In a small basin or pan boil two rubber catheters for five minutes

- 3) Boil a basin of water with five cotton pledgets in it for ten minutes and let cool
 - 4) Have patient lie on bed, close to the right side, with knees well flexed
 - 5) Drape to prevent exposure
 - 6) Place a newspaper covered with folded towel or diaper under patient's buttocks
 - 7) Cover the seat of a chair with a clean newspaper and spread over it a paper napkin
 - 8) Place on the chair seat the following items
 - a) Newspaper bag
 - b) Basin of boiled water with cotton
 - c) Sterile catheters in container
 - d) Three pieces of clean, dry cotton
 - 9) Wash hands under running water for two minutes using soap
 - 10) Put finger cots on thumb and index fingers of left hand, scrub hands for three minutes, and with these fingers separate labia
 - 11) Using right hand, take a boiled cotton pledget, wipe down left labia and discard pledget. Take another and wipe down right labia. Discard pledget
 - 12) With the third pledget wipe downward over urinary meatus and discard pledget
 - 13) Grasp the catheter four inches from the end and insert into urethra
 - 14) Fill the specimen bottle with urine, pinch catheter, remove specimen bottle and replace with waste container
 - 15) Empty bladder and withdraw catheter
 - 16) Take last piece of dry cotton, dry patient if it is necessary, and discard pledget. Make patient comfortable
 - 17) Empty waste urine, wash container and catheter and have family boil them for five minutes
 - 18) Label specimen and put it in small paper bag to take to laboratory
 - 19) Record date and time of treatment, reason, quantity of urine obtained, and any unusual symptoms
 - 20) On arrival in clinic, examine the specimen, record results on patient's record
- (6) Bladder irrigation
- (a) Adaption to home procedure same as for catheterization
 - 1) Prepare solution in a boiled container from which it is easy to pour

(7) Ear irrigation

(a) Equipment

- 1) Ear syringe
 - 2) Cup for solution
 - 3) Basin to catch return flow
 - 4) Towel and paper to protect bed
 - 5) Sterile equipment and solution must be used
 - 6) Boil syringe for three to fifteen minutes according to altitude immediately before use and after irrigating each ear when both ears are irrigated.
- METICULOUSLY AVOID ANY PRESSURE FROM FLUID

(b) Family may be taught to prepare solution and equipment before the nurse arrives

(8) Intramuscular and hypodermic injections

(a) All orders for intramuscular injections must be written and signed by the physician in charge. Be sufficiently familiar with the drug you are asked to give to detect any unfavorable sign or symptoms which the patient might develop. Watch all patients carefully for evidence of contra-indications for continuing the medication. Notify the physician immediately if patient has a reaction. Explain to patient what you are giving and the expected results

(b) Equipment

- 1) Sterilize by boiling for, at least, five to fifteen minutes in enamel instrument basin. (See directive for altitude)
 - a) Leur's syringe - 2 cc. or 5 cc.)
 - b) Needles - Gauge 18-20-22-26
Length $1\frac{1}{2}$ "-2"- $\frac{1}{2}$ "
 - c) Cotton balls or pledgets

2) Alcohol 70%

3) Drug to be used

(c) Procedure

1) Preparation of drug

a) The medication usually used comes in vials or ampoules. It should be mixed by inverting and rotating gently to assure complete suspension

2) Preparation of patient for intramuscular injections

a) Ask the patient to lie down on the bed on his abdomen with toes turned in and arms relaxed at sides. If the patient can stand up, have him turn toes in with his weight resting on his arms as he leans forward on a table or chair

3) Technique of administration

a) The technique of getting the drug into the syringe varies according to the nature of the drug and the type of container

(1. If the drug is in a bottle or vial with a rubber cap, wipe cap with an alcohol pledget before inserting the needle

- (2. For thick or heavy oily substances, if a wide mouthed container, draw directly into the syringe before attaching the needle. If in a narrow mouthed container draw up through 18 gauge needle and then replace this with 20 or 22 gauge needle before making the injection
 - (3. For thin or non-oily medication draw up directly through the 20 or 22 gauge needle attached to the syringe
 - (4. In making injections, select the inner angle of the outer upper quadrant of the buttocks, alternating sides for each injection. It is important to select this area to avoid striking the sciatic nerve and thus cause a temporary paralysis. Cleanse area with an alcohol sponge, hold the flesh down firmly, and with a quick firm motion insert the needle into the proper site.
 - b) Withdraw needle slightly and pull out on the plunger to ascertain if the needle is in a vein or capillary
 - c) Inject medication slowly
 - d) Withdraw needle rapidly. When indicated, massage the site of injection
 - 4) Care of equipment
 - a) Before putting equipment away, make sure that the syringe and needle are thoroughly cleansed
- (9) Dressings
- (a) Introduction

The dressing may be the only care given, some member of the family having been taught to give general nursing care. The nurse, however, is responsible for the quality of the total care
 - (b) Method of application

Economy of the patient's supplies should be practiced

 - 1) Procedure
 - a) A reliable helper may be taught to prepare the necessary articles and equipment such as cotton, gauze, bandage, ointment, solution, etc. If a solution is ordered and the helper is unable to prepare it, she may be instructed to have hot and cold sterile water, and equipment necessary to make solution boiled before the nurse arrives
 - b) Make large newspaper bag
 - (1. Remove from nursing bag, in addition to the general care equipment
 - (a. Several paper towels

- { b. Scissors
- { c. Forceps - boil for five to fifteen minutes depending on altitude
- { d. Applicator sticks
- { e. Tongue depressors
- c) Prepare clean work area
- d) On a paper towel arrange
 - { 1. Basin with sterilized instrument
 - { 2. Dressing package, open. Sterile cotton, open
 - { 3. Medications with covers removed
- e) Dressing
 - { 1. Protect area under wound with a clean towel adequately reinforced (news-paper pad may be used)
 - { 2. Wash hands thoroughly - DO NOT DRY
 - { 3. Remove dressings from wound with forceps. Place in a large paper bag. Dressings which have come in contact with wound should not be re-used
 - { 4. Give treatment ordered
 - { 5. Apply dressings, with forceps
- f) After care
 - { 1. The nurse is responsible for the prompt and proper care of soiled dressings, as well as for teaching the family how to wash, roll and prepare bandages for future use
 - { 2. Boil instruments 5-15 minutes, according to altitude, then cleanse and dry

3. Selected diseases and conditions

a. Aging (Geriatrics)

- (1) At what age does one become old? 50, 75, or 90 years? Old age is only a part of the cycle of life which begins at birth and ends with death. It can not be designated as a certain date. Some people are old at 30, others are young at 70
- (2) Trend toward an aging population is definite. Five to seven percent of the present population is now 65 years or older. It is estimated that 50% of our population will be in this upper age bracket by 1980

Chronic illness finds more victims in this age group than the younger age group. Seventy percent of the chronic and aged patients can be cared for in the home

- (3) The public health nurse's responsibilities
 - (a) The nurse will have an opportunity to teach and supervise the patient and his family in the essentials of bedside nursing
 - (b) Understand and interpret the mental hygiene of aging
 - (c) Every public health nurse will want to be familiar with the changing patterns of aging, so that she can give the best service possible to the family
- (4) Suggested reference
 The Family Health Series #8, Community Service Society, Department of Educational Nursing, 105 East 22nd Street, New York 10, New York - 15 cents per copy

b. Brucellosis (Undulant fever, Malta fever)

- (1) An infectious disease of world wide distribution, affecting domestic animals primarily. The disease is caused by small bacilli known as Brucella organism, of which there are three types
 - (a) Associated with goats (caprine or melitensis)
 - (b) Swine (porcine or suis)
 - (c) Cows (bovine or abortus)
 Whenever cattle are associated with infected goats or hogs they may become infected with caprine or porcine strains and transmit them to man
- (2) Man acquires the disease by drinking raw milk from infected cows or goats, but he may acquire it by ingesting contaminated food other than milk or by direct contact with infected animals or by handling their carcasses. (Occupational disease among farmers, veterinarians and meat handlers)
- (3) Organisms are destroyed by pasteurization of milk and by direct sunlight. Incubation period 6 to 14 days
- (4) Acute stage
 - (a) Characteristic symptoms
 - 1) Headache
 - 2) Malaise
 - 3) Weakness
 - 4) Anorexia
 - 5) Constipation
 - 6) Backache
 - 7) Afternoon elevation of temperature and increase in intensity of symptoms
 - 8) Late evening or night chills and sweats
 - 9) Arthralgia and muscular pains
 - 10) Myalgia, may be accompanied by a feeling of stiffness -- permanent impairment of joints does not usually occur

- 11) Meningeal involvement may cause such symptoms as severe headache, vertigo, nuchal rigidity, aphasia, psychic disturbances and various forms of paralysis
- 12) Gastro - intestinal symptoms include
 - a) Anorexia
 - b) Constipation
 - c) Nausea and vomiting in more severe cases
 - d) abdominal pain
- 13) Cough not infrequent with mucoid or mucopurulent sputum
- 14) Loss of weight almost constant
- 15) Fever may be continuous, remittent or intermittent (undulant, febrile waves lasting from a week to four weeks alternating with afebrile periods lasting several days)
- (5) Localized and chronic forms occur
- (6) Laboratory findings
 - (a) Spinal fluid may show increased pressure, pleocytosis, increase of albumin, and a decrease of globulin and sugar
 - (b) Culture of blood, spinal fluid secretions, excretions or excised tissue
 - (c) Agglutination tests
 - (d) Freshly drawn white corpuscles to phagocytize a suspension of Brucella organisms in vitro
 - (e) Skin test
- (7) Nursing care
 - (a) Acute stage
 - 1) Special provision to protect bedding from drenching sweats
 - 2) Daily baths - disagreeable odor of perspiration
 - 3) Skin care
 - a) Tepid baths to reduce high temperatures
 - 4) Isolation as for Disease in Group III
 - 5) Bed rest seven to ten days after temperature is normal as ordered by physician
 - 6) Activity gauged by appreciable gain in strength, digestive functions normal, and restoration of weight
 - 7) Diet as ordered by physician--usually planned to protect the liver; high carbohydrate, moderate protein, low fat, adequate mineral and vitamin content. Fluid intake 3000 cc.
 - 8) Ice cap often relieves headache
 - 9) Cradle often relieves pressure to sore joints
 - 10) Psychotherapy towards reassurance of patient; and the family's acceptance that patient is not neurotic or malingering
- (8) Active research and study of the disease may produce changes in treatment and care. Secure current information

c. Cancer

Cancer is in second place as a leading cause of death in the United States: and in fourth place as a leading cause of death in New Mexico

(1) Objective

- (a) Prevention through teaching of sound health measures and encouraging the habit of routine physical examinations at periodic intervals for the early discovery of suggestive symptoms or laboratory testing results; the giving of skilled nursing care; the teaching of a member of the family to give good general care; and the bolstering and maintenance of the relationship between patient, family and the family physician

(2) Case finding

- (a) Nurses should be familiar with the seven danger signals
 - 1) Any sore that does not heal, particularly about the tongue, mouth or lips
 - 2) A painless lump or thickening, especially in the breast, lip or tongue
 - 3) Irregular bleeding or discharge from any natural body opening
 - 4) Progressive change in color or size of a wart, mole or birthmark
 - 5) Persistent indigestion. Do not wait for loss of weight
 - 6) Persistent hoarseness, unexplained cough, or difficulty in swallowing
 - 7) Any change in normal bowel habitsPrompt medical care should be advised whenever a patient has any of these symptoms

(3) Care of the sick

- (a) Working with the family physician, follow orders and with his approval, teach attendant or relative techniques of procedures by demonstration, and supervise such care at regular intervals
- (b) Upon approval of family physician, and with such changes as ordered, for giving and teaching nursing care according to the Treatments in the Morbidity Service
- (c) Upon approval of the family physician, carrying out such other procedures as outlined in the Cancer Control Public Health Nursing Manual, National Cancer Institute, Public Health Service
- (d) Mental health teaching
- (e) Helping family to make social adjustments
- (f) Knowledge and use of local agencies as needed

(4) Educational follow-up of known cases

- (a) Upon receipt of case report card
 - 1) Contact family physician or clinic for

- a) History of case
 - b) Treatment
 - c) Information regarding what has been told to the family or patient concerning the case
 - d) Physician's orders for home care
 - e) Medical approval for public health nurse to teach and supervise an attendant or member of the family to give nursing care
- (5) The Nursing Manual of the U. S. Public Health Service, Cancer Control Branch, National Cancer Institute, will be used as the official manual
- d. Diabetes Mellitus
- The increasing instances of diabetes is a matter of concern to all persons interested in health
- (1) Case finding
- (a) Pre-disposing factors — heredity, obesity, infection, age and race
 - (b) Common symptoms — excessive thirst, excessive passing of urine, excessive hunger, loss of weight and strength, boils and carbuncles, dermititis and pruritus vulvae, failing vision, blurring vision and cataracts, gangrene (lower extremities) and coma
- (2) Case management
- (a) It is important that the patient be under regular medical supervision
 - (b) Nursing care
 - 1) On medical order
 - a) Instruct responsible member of family to
 - 1. Calculate diet
 - 2. Administer insulin
 - 3. Observe for symptoms of diabetic distress
 - 4. First aid measures
 - (c) Suggested reference
 - 1) "The Family Health Series Guide" #36, which has listed 100 gram portions of vegetables, classified according to carbohydrate content. This pamphlet may be obtained from the Community Service Society, Department of Educational Nursing, 105 East 22nd Street, New York, N. Y. The series may be purchased for twenty-five cents
- e. Heart disease
- Heart disease is the leading cause of death in the United States, and is the leading cause of death in New Mexico. Prevention of certain heart troubles is moving ahead. Two lines of attack against heart disease, are treatment and prevention
- (1) Case finding
- Some of the underlying causes which appear to operate in producing heart disease are*
- (a) Congenital - little can be done about it
 - (b) Acute communicable diseases, diphtheria, scarlet fever and pneumonia - much can be done in preventing these

*Adapted from: Mustard, Harry S., Introduction to Public Health, 2nd Ed., 1945, The Macmillan Co., New York, N. Y.

- (c) Infections - tonsillar, acute rheumatic fever, chorea etc. - education is required
- (d) Syphilis, prevention and treatment - education is required
- (e) Arteriosclerosis - the heart becomes involved in general changes throughout the circulatory system
- (f) Functional heart trouble - (troubles of sound heart). Often mistaken by patient for organic trouble. Common symptoms of functional heart are: Shortness of breath, pain in chest, easily fatigued, faintness, palpitation, dizziness, trembling, and sighing
- (2) Nursing care
 - (a) Working with family physician, follow orders and with his approval, teach attendant or relative techniques of procedures by demonstration, and supervise such care at regular intervals
 - (b) Upon approval of family physician, follow instruction with such changes as ordered for giving and teaching nursing care according to the Outline for Nursing Care and Treatments under Morbidity Service
 - (c) Public Affairs Pamphlet #137, "Know Your Heart," is a good reference
- f. Multiple Sclerosis, (Disseminated cerebrospinal sclerosis; Insular sclerosis)*

Multiple sclerosis is one of the most chronic, intermittently progressive diseases, of the nervous system characterized anatomically by patches of sclerosis of varying size scattered throughout the brain and spinal cord. It is found in persons of widely varying occupations and in all strata of society

 - (1) Characteristic symptoms in well-developed cases are
 - (a) Increasing weakness in lower extremities
 - (b) A slow, halting, scanning (words broken up into syllables) speech
 - (c) A coarse tremor, especially marked in the hands, and appearing only during the performance of voluntary movements (intention tremor)
 - (d) Involuntary oscillation of the eyeballs, or nystagmus, upon fixing a near object or on looking to one side
 - (e) Defective vision and optic atrophy
 - (f) Various subjective disturbances of sensation, such as headache, giddiness, and numbness or tingling in the limbs

*Based on Stevens, Arthur A., and Ambler, Florence Anna, Medical Diseases for Nurses, W.B. Saunders, Co., Philadelphia, 1940 4th Ed. Revised, pp. 445-446, and, Brown, Amy Frances, Russell, L. Cecil, Medical Nursing, W.B. Saunders, Co. Philadelphia 1945 Reprinted, 1947, pp.344-45

- 1) May be paresis of the ocular muscles
(often fleeting at first) mental impairment, and epileptiform or apoplectiform seizures
- (g) Duration variable - average 10 years. Remissions — common
- (2) Treatment and nursing care
 - (a) Advise medical care of general health and hygiene, and treatment of focal infections
 - (b) Well balanced diet, to avoid overweight
 - (c) Rest as necessary
 - (d) Attention to mental state is all important. Boost morale
 - (e) If hemiataxia occurs, the patient may learn to avoid staggering by habitually leaning toward the more normal side
 - (f) The sensation of slapping the ground with the toes may often be mitigated by placing the heel on the ground first and rolling the weight along the outer edge of the foot to the toe
 - (g) Some outdoor living provided if possible
 - (h) position changed frequently to protect against decubitus (bed sore)
 - (i) Teach patient to avoid intercurrent infections to prevent exacerbations
- (3) Active research is being conducted. Current information may be secured from National Multiple Sclerosis Society, 270 Park Avenue, New York, N. Y.

g. Rheumatic Fever

Because of the increasing number of cases among children, public health workers are focusing their attention upon the cause of the disease--80% - 90% of deaths from heart disease among children, 5 to 19 years of age is due to rheumatic infection*

(1) Case finding

Case incidence will naturally be greater than the death rate. Nurses and teachers should be alert to health conditions of all children. Observation follow-up on school absence of the patient gives the nurse an opportunity to observe illness. Signs and symptoms suggestive of substandard health such as failure to gain weight, pallor, poor appetite, fatigue, frequent colds and sore throats, scarlet fever or any known streptococcal infection, unexplained nosebleeds, unexplained fever, pain in arms, legs and joints, unusual restlessness, irritability, twitching or jerky motions, behavior and personality changes, decreasing accomplishments by the school child

*Children's Bureau Publication #322, 1948, "Childhood Mortality from Rheumatic Fever and Heart Disease," Children's Bureau, Washington, D. C. p.1

(2) Nursing care

The nurse may find suspected cases of rheumatic fever and will advise the patient to obtain medical supervision. The rheumatic fever patient should be protected from respiratory infections. The patient should be instructed regarding the importance of good hygiene practices. The nurse will cooperate with the family, school, medical society and social welfare

The nurse under direction of the physician instructs the attendant in nursing care of the patient, by demonstration and follow-up supervision

(3) Public Affairs Pamphlet, "Rheumatic Fever - Childhood's Greatest Enemy" is a good reference

h. Safety

(1) National aim: prevention of national, state, local, school, home and community accidents is a public health problem

(a) Care for life and save lives. In 1947 more children between ages of 2 to 15 years died of accidents than died of all communicable diseases put together

(b) Provide a safe place in which to live, work and play

(2) Extent of problem and program outline

(a) Review statistics of the New Mexico State Health Department - (the ten leading causes of death in New Mexico)

(b) Consult "Accident Facts" published by National Safety Council, 20 North Wacker Drive, Chicago 6, Illinois for current statistics and national program

(c) Consult New Mexico State Police, New Mexico Highway Department, or New Mexico Department of Education, Safety Division

(d) Consult local chapter of The American Red Cross, Chairman of Safety

(e) Every nurse should know facts about accidents their causes and prevention

(3) Program objectives

(a) Arouse in nurses an awareness of the safety problem

(b) Create a desire to develop new habits which will prevent injury to self and others

(c) Nurses to incorporate safety teaching in their everyday schedules without additional service

I. CRIPPLED CHILDREN'S SERVICES

1. Administration

Services to crippled children, including those living on Indian reservations and pueblos, are administered by the Department of Public Welfare with the cooperation of the Department of Public Health. The division functions according to an annual plan approved by the United States Children's Bureau

2. State staff

- a. A Supervisor of Crippled Children's Services, who is a trained medical social worker, is responsible for the administration of the program, and the authorization of all services
- b. A Medical Advisor, who is a pediatrician, acts in a consultant capacity to the division, and renders pediatric service to children at itinerant clinics
- c. A Medical Advisor, who is an ophthalmologist, acts in a consultant capacity
- d. Two Orthopedic Nursing Consultants, who are trained in public health nursing and physical therapy are responsible for
 - (1) Integrating crippled children's service in the generalized program of public health nursing
 - (2) Interpreting crippled children's service program and related subjects to nurses in the field of public health, other professional groups and lay persons
 - (3) Interpreting and instructing in the use of crippled children's record forms
 - (4) Interpreting and demonstrating orthopedic nursing techniques to nurses in the field of public health regarding preventive and remedial aspects
 - (5) Planning and participating in programs for the prevention of crippling defects
 - (6) Assisting nurses in the field of public health in helping the patient and family to adjust psychologically to the crippling condition and treatment prescribed
 - (7) Assisting nurses in the field of public health in the interpretation of clinical findings and recommendations for treatment
 - (8) Assisting nurses in the field of public health in determining selection of patients for diagnostic examination
 - (9) Establishing and conducting itinerant clinics with assistance and participation of public health nurses
 - (10) Interpreting to parents the recommendations made at time of clinic examination
 - (11) Rendering direct service to children requiring special supervision in areas where a nursing vacancy exists

3. Objectives

- a. To locate all children who are crippled, or who are suffering from a condition which leads to crippling
- b. To provide facilities for diagnosis, hospitalization, and after care
- c. To assist in the complete rehabilitation of those children who have residual disabilities

4. Eligibility for care

- a. Children under 21 years of age are accepted by the division if they are in need of orthopedic care, plastic repair, those with acute illnesses or injuries which might result in a crippling condition

5. Program for specific care

- a. Children born with harelip are sent to the hospital for repair when they have regained their birth weight and are weaned. If accompanied by cleft palate, the palate repair is done at 16-17 months of age. Cleft palate without harelip may be repaired at 16 months of age if the baby is free from respiratory infection
- b. Children born with clubbed feet are admitted to the hospital for correction as soon as it is evident that they are progressing satisfactorily (1-2 months) and have been weaned. Conditions such as, congenital dislocation of the hip, club foot and hare-lip respond best to early treatment
- c. Services are given for eye conditions which are amenable to treatment by an ophthalmologist, such as, inflammatory conditions of the eyeball, lids and related tissues; cataract; glaucoma; pterygium; nystagmus; trachoma; tumors; ptosis; injuries including presence of foreign bodies; strabismus; refractive errors which would result in visual handicap or blindness; and congenital malformations
 - (1) The Division of Services for the Blind, administered by the Department of Public Welfare will continue to plan for schooling and vocational training of totally blind children. The Crippled Children's Service will provide glasses only as part of the ophthalmological treatment. If, after examination, the condition is found to be due only to a simple refractive error, and glasses are prescribed, provision for same should be planned for through some local source
- d. If, in the opinion of the health officer, private physician or nurse, the crippling condition is such that care is emergent, the local welfare department should be so informed. Authorization for such care will then be given by the Supervisor of Crippled Children's Services. If the condition is not an emergency and orthopedic care is indicated the patient may attend a clinic at the Carrie

Tingley Hospital or be held for diagnostic examination at an itinerant clinic. Clinics are held every Thursday, at 1 P.M. at the Carrie Tingley Hospital, excepting the last Thursday in the month which is reserved for an itinerant clinic. Itinerant clinics are held throughout the State at regular intervals. A yearly orthopedic clinic schedule is sent to each health and welfare office throughout the State. These clinics are conducted by the staff of the Carrie Tingley Hospital. Personnel includes the orthopedist, a physical therapist and a brace maker. A pediatrician is present to examine all new patients, and to check any patient known to the service if the need is indicated. Nutrition consultation is provided by the nutritionist on the staff of the State Health Department

- e. Plastic clinics are held at specified times. Children are brought to the itinerant clinic for recheck and recommendation; new patients for diagnosis and recommendation. Public health nurses cooperate with the local welfare departments in selecting the children who should attend the itinerant clinic. Local public health nurses are assigned to assist at the clinic, and any may, with permission of the district health officer, attend for purely educational reasons
- f. The local welfare department is responsible for arranging patient examination, hospital care, transportation and overnight care if needed. Nurses should not transport crippled children in their own cars or state owned cars
- g. Children having orthopedic conditions and requiring hospitalization are sent to the Carrie Tingley Hospital at Hot Springs, New Mexico, and those in need of plastic repair are hospitalized at the Southwestern General Hospital, El Paso, Texas. Children requiring an eye examination are referred to an ophthalmologist on an individual basis
- h. Educational records for patients of school age accompany the patient who is to be hospitalized at the Carrie Tingley Hospital in order that school facilities can be more adequately arranged
- i. Copies of hospital discharge reports and examination reports are sent by the Crippled Children's Service Division to the respective county welfare department and to the county health department for follow-up

6. Functions and responsibilities of the public health nurse

- a. The county health departments cooperate with the Crippled Children's Service Division by locating and referring children in need of care, and by providing nursing supervision of the patient in the home, as a part of the generalized program. The nurses, under the direction of the district health officer, and with the assistance of all nursing consultants perform the following activities

- (1) Assist in the prevention of conditions contributing to crippling disabilities by
 - (a) Recognizing and assisting with the correction of environmental and other factors which influence crippling conditions, such as inadequate maternal care, tuberculosis, rickets, accidents and inadequate school seating and lighting
 - (b) Assisting in preventing the spread of infectious diseases which may result in a crippling condition such as; poliomyelitis, tuberculosis, and interstitial keratitis
 - (c) Preventing contractures and deformities by attention to posture of bed patients during acute and chronic illnesses
 - (d) Preventing further or permanent disability resulting from congenital malformations and birth injuries, by early recognition and prompt referral for care
 - (e) Preventing orthopedic disabilities resulting from poor posture
 - (f) Assisting in the prevention of blindness, conservation of vision and restoration of sight
- b. Locating and referring all children having a motor handicap, those needing plastic repair, and those requiring ophthalmological care
 - (1) Conference with parent (s) regarding
 - (a) Child's condition
 - (b) Treatment given for existing condition (past and present)
 - (c) Family's plan for continued care
 - (d) Crippled Children's Service if indicated, as
 - 1) Need for specialized service
 - 2) When there is probable financial need
 - (2) Application for service
 - (a) The application should be made on the printed form CCS 33-R and submitted to the local welfare department. The parent should be instructed to contact the local welfare department to complete necessary forms for service. Application is accepted regardless of the financial status or legal settlement of the family involved
 - (b) The clerk in the local office of the Department of Public Health, responsible for registration of births, should immediately report to the nurse any infant reported to have a congenital malformation or birth injury, so prompt referral for care can be made, and those with eye conditions which are amenable to treatment by an ophthalmologist

c. Giving care to crippled children

(1) Health supervision

(a) Supervising the general health of patient and family

(b) Immunizing children against smallpox, diphtheria and whooping cough in accordance with the MCH policies. (If immunization is done following referral a statement should be submitted to the local welfare department)

(2) Helping the family and patient to make a psychological adjustment to the treatment of any residual disability

(3) Giving, teaching and supervising the care of patients in apparatus, such as casts, splints, frames and braces

(a) Inspecting casts for odor, pressure, weakness or tightness

(b) Inspecting the brace for correct fitting and use, proper lacing, application of stocking or vest to avoid irritation of part, and protection of leather, and proper oiling to maintain repair and function

(c) Inspecting corrective shoes, stressing the need for maintenance of adequate repair

(4) Assisting the family in understanding and supervising the carrying out of specific orders

(a) During acute illness as in poliomyelitis

(b) Following surgery if dressings or treatment are required

(c) Special diets or feeding such as cleft palate

(d) Exercises and crutch walking

(e) Special activities such as sun baths and rest periods

(5) Assisting the family in adaptation of home equipment

(6) Guiding activities to prevent harmful fatigue

(7) Interpreting speech education to parent and teacher for children having had plastic repair of cleft palate and those with cerebral palsy

d. Integrating services by reporting to and consulting the local welfare department regarding

(1) Social problems

(2) Recreation

(3) Education

(4) Vocational rehabilitation

(5) Need for reexamination

(6) Need for reapplication of cast

(7) Need for brace adjustment

(8) Need for renewal of corrective shoes

(9) Intercurrent illnesses

(10) Change of address

(11) Termination of nursing service

e. Assisting at itinerant clinics

- (1) Selection of building
- (2) Clinic set up
(refer to "Management of crippled children's itinerant clinic")
- (3) Pre-clinic instructions to family
 - a) Bath before clinic
 - b) Appliances to be brought to clinic
 - c) Clinic procedure
- (4) Assisting physicians at examination
- (5) Reporting to physician pertinent information relative to progress and home or environmental conditions which might influence the medical recommendations

f. Informing professional workers, families and the county at large of services available to crippled children

7. Management of itinerant clinic

a. Required space - ground floor if possible

- (1) Room or hall sufficiently large to be used for registration and waiting room
- (2) Two separate rooms or partitioned space - for dressing rooms
- (3) One large room to provide ample space for 3 large examining tables, 1 table for use by physical-therapist and/or brace maker, 1 table for records and 1 table for utility purposes
- (4) One smaller room for physical examination
- (5) One small room or space for plastic examination (if Plastic Surgeon is to be present)
- (6) Space for nutritionist
- (7) Toilet facilities
- (8) X-ray facility (responsibility of local Director of Department of Public Welfare)

b. Local personnel

- (1) 4 or 5 nurses from the field of public health
- (2) 5 volunteer workers (responsibility of local Director of Department of Public Welfare)

c. Registration and waiting room

- (1) Desk or table for registration
 - (2) 1 chair for registrar
 - (3) 1 chair for worker
 - (4) 1 chair for parent
 - (5) 1 chair for patient
 - (6) 30 or more chairs for parents and children
- Patients are registered by a representative from the local welfare department as they enter the waiting room and are given
- (a) White card for recheck examination - or
 - (b) Pink card and referral form CCS 33-R for initial examination. The card of the patient who is to be seen by the plastic surgeon is so designated
- Patients are examined in the order of their registration
A volunteer escorts patients from waiting room to dressing rooms

d. Dressing rooms

- (1) Boy's dressing rooms
 - (a) Table for clinic gowns and breech cloths
 - (b) 12 chairs or benches
 - (c) Gowns and breech cloths are provided by Crippled Children's Service
- (2) Girl's dressing rooms
 - (a) Table for gowns, brassieres and breech cloths
 - (b) 12 chairs or benches
 - (c) Gowns, breech cloths and halters are provided by Crippled Children's Services

A volunteer in each dressing room is responsible for the patient being properly clothed for examination, and if necessary assists in the dressing

Girls - apply breech cloths and gown - (panties and halters tightly fitted). (Own panties and brassieres may be worn if adequate)

Boys- apply breech cloths and gown - (shorts tightly fitted) (Own shorts may be worn if adequate) Shoes, braces, corrective corsets or any other apparatus are not removed but remain in place for the orthopedist's inspection. Two rows of chairs are placed on the outside of the dressing rooms in close proximity to examining rooms, one row for new patients and one for rechecks. Children are seated in order as above stated. (One row for examination by plastic surgeon when present)

e. Nutritionist's room

- (1) 1 small table or card table
- (2) 3 chairs
- (3) (Nutritionist furnishes own diet forms)

f. Physical examination room (2 nurses assisting)

- (1) 1 examining table (a plain, substantial table long enough to accommodate child in supine position) - covered with pad, sheet, and paper sheeting
- (2) 1 small table for nurse who takes dictation
- (3) 1 table for hand washing equipment
- (4) 1 container for waste
- (5) Equipment furnished by Crippled Children's Services
Forms CCS 268 for physical examinations, (clipped with form CCS 33-R when completed and handed to parent following examination)

1 pencil or 1 pen and ink	Paper towels
Clips	Soap
1 tape line	Thermometer, tray,
1½ inch bandages	(alcohol, cotton balls)
Tongue blades	Cotton
1 pitcher for water	Paper sheets
1 basin for water	Adhesive tape
Sterile gauze dressings for use	in covering possible
skin abrasions or wounds	
Doctor's coat	

g. Procedures

- (1) Nurse No. 1
 - (a) Nurse takes physician's dictation
- (2) Nurse No. 2
 - (a) Nurse calls first patient in row
 - (b) Removes gown - assists clinician with the examination
 - (c) Replaces gown, shoes and stockings following the examination
 - (d) Gives completed forms to parent
 - (e) Returns child to his chair in the row formerly stated, to await plastic or orthopedic examination
 - (f) Accompanies next child to table for examination

h. Orthopedic examining room

Three nurses are required, one to assist at each table. Equipment for orthopedic examinations are brought by the Carrie Tingley Hospital personnel

- (1) 1 table at entrance to hold x-rays and hospital histories brought by the staff of hospital
- (2) 1 table for equipment and hand washing
 - (a) Basin
 - (b) Pail
 - (c) Soap
 - (d) Paper towels
 - (e) Thermometer
 - (f) Alcohol
 - (g) Cotton
 - (h) 6 tongue blades
- (3) 3 examining tables covered with pad, sheets and paper sheeting, placed in parallel positions with screens or partitions between
- (4) 2 chairs placed at each examining table. (One for parent and one for physician)
- (5) Carpet strips between each examining table
- (6) 1 table for physical-therapist and/or brace maker placed at end of room
- (7) Carton box placed near hand-washing table
- (8) Extra paper sheets placed over screens

The child who has previously been examined, accompanied by parent, is taken from the row outside of the examining room, gives the recheck card, to the volunteer at the record table. The Hospital records and X-rays are drawn and given to the nurse at the respective examining table. The "new" patient is taken to the table and the CCS 33-R and Physical Examination Report is placed for the orthopedist's attention. Following examination these reports are given to the record volunteer to be kept apart from the Carrie Tingley Hospital records. The nurse at the examining table assists the child to the table, unties the gown, removes it, and makes sure the under clothing fits properly. Examination is then given by the orthopedist. Appliances are removed at the orthopedist's request. The gown is replaced and the child is directed to the brace maker, physical-therapist or nutritionist, as advised by the orthopedist, after which the child is returned to the dressing room. If an X-ray is ordered

the child is dressed and is accompanied by a welfare worker to the laboratory. Following the X-ray the patient is returned to the examining room at which time the X-ray is read and further recommendation is made.

1. Plastic examination room (1 nurse assists physician and takes notes)

- (1) 1 table or desk
- (2) Pen - ink or pencil
- (3) 3 chairs
- (4) Carton box for waste
- (5) Table or bench for hand washing equipment
 - a) basin
 - b) pitcher of water
 - c) soap
 - d) towels
- (6) Tongue depressors

8. Brace Instructions*

Braces are expensive items to construct and involve considerable mechanical labor and material. The following instructions for their care should be closely followed

- a. It is essential that braces be inspected and oiled three times a week at ankle, knee, and hip joints. (Ordinary machinery oil is excellent)
- b. The soles and heels on corrective shoes must be observed constantly to see that heels are level and that soles are in good condition. This is necessary in order to receive the correct benefit from the appliance. Shoes should be taken to a shoe shop immediately for repairs when they begin to wear.
- c. When shoes are mailed to the hospital to be attached to braces or for other purposes they must be of all leather type, leather soles with a straight inner last. **NO COMBINATION NOR RUBBER SOLED SHOE can be applied to a brace.**
- d. When a brace breaks kindly mail the entire brace to the Hospital so that the brace can be properly repaired and aligned. If new shoes are required at that time, kindly state the size or send an outline of the patient's foot, preferably an all leather shoe should be fitted to the patient and sent to the hospital along with the broken brace
- e. Discarded braces and corrective appliances that are supplied by the Hospital without cost to the patient must be returned to the Hospital. When mailing braces or shoes to the Hospital please state the correct mailing address, also the name of the patient and parents or guardian. If continued neglect, such as lack of oil, tightening of screws, etc., is noticed by the Hospital, we promptly reserve the right to refuse repair of such appliances at cost
- f. Your cooperation is requested regarding proper care of all appliances so as to obtain the utmost benefit that the braces and appliances are intended to give

*Carrie Tingley Hospital, Hot Springs, N. Mex.

9. Orthopedic terminology

Abduction	- Movement outward from the midline of the body
Acetabulum	- A cup-shaped depression on the hip bone into which the head of the thigh bone is fitted to make up the hip joint
Achondroplasia	- A disturbance of bone growth resulting in dwarfing of the body
Adduction	- Movement toward the mid line of the body
Adhesion	- The process of adhering or uniting of two surfaces by fibrous bands
Anesthesia	- Loss of sensibility to pain
Ankylosis	- Stiffening or fixation of a joint
Arthrectomy	- Removal of a joint
Arthritis	- Inflammation of a joint
Arthrodesis	- The stiffening of a joint by operative means
Arthroplasty	- An operation on a stiff joint to restore, as far as possible motion and usefulness
Arthrotomy	- Cutting into a joint
Articulation	- A joint
Astragalectomy	- Removal of the astragalus
Ataxia	- Loss of muscular coordination
Atrophy	- A wasting of body tissues
Babinski	- Bending upward of the big toe instead of downward, when the sole of the foot is tickled
Bell's Palsy	- A paralysis of the face muscles
Bone graft	- Transplanting bone from one part to another
Bursa	- A closed sac containing fluid to relieve friction where one part rubs over another, such as between a muscle and a bone
Bursectomy	- Removal of a bursa
Bursitis	- Inflammation of a bursa
Calcaneus	- The heel bone
Caries	- Bone decay
Charcot Joint	- A disintegration of a joint due to syphilis
Chondrectomy	- Removal of cartilage
Chondritis	- Inflammation of cartilage
Congenital	- Existing at birth
Coxa Valga	- A curvature of the neck of the femur in which the angle with the shaft becomes greater
Coxa Vara	- A curvature of the neck of the femur in which the angle with the shaft becomes less
Coxa Plana	- A flattening of the head of the femur
Coxitis	- Inflammation of the hip joint
Cretinism	- Dwarf-like development of a child due to absence of the thyroid gland
Cubitis Valgus	- When the carrying angle of the arm is decreased
Cubitis Varus	- When the carrying angle of the arm is increased
Diaphysis	- The shaft of a bone between the epiphyses at each end
Diplegia	- Paralysis of corresponding parts on both sides of the body
Dorsiflexion	- Bending toward the back of the part, as in raising the foot upward
Ectrodactylia	- Congenital absence of any of the toes or fingers
Endocrine	- Pertaining to the internal secretion of a gland
Epiphysis	- The end of a long bone which has to do with its growth
Equinus	- Foot turned downward
Erb's Palsy	- Paralysis of the muscles of the upper arm from birth injury
Excision	- Operative removal of a part of the body
Exostosis	- A bony tumor springing from the surface of a bone
Extension	- The act of straightening the joint of a limb

Fibrosis	- The formation of dense scar-like tissue
Fixation	- The art of making firm
Flaccid	- Relaxed, flabby
Flexion	- Bending of a joint to approximate the part it connects
Fragilitas Ossium	- A condition in which the bones become brittle
Fusion	- Joining together of parts
Genu Recurvatum	- A bending backward of the knee
Genu Valgum	- Knock-knee
Genu Varum	- Bowleg
Hallux Valgus	- A deviation outward of the great toe
Hallux Varus	- A deviation of the great toe inward
Heliotherapy	- Treatment by means of sunlight
Hemiplegia	- Paralysis of an arm and a leg on the same side
Hydrocephalus	- An enlargement of the head which is usually of congenital origin
Hypertrophy	- Overgrowth of tissues
Immobilization	- The act of making immovable
Ischemic	- A shutting out of the blood supply to a part
Kyphosis	- A hunch back. A convexity backward of the spine as seen in tuberculosis of the spine
Laminectomy	- Removal of the laminae of the vertebrae to expose the spinal cord
Little's Disease	- A form of birth paralysis due to a damaged brain or spinal cord
Lordosis	- Hollow spine. A convexity forward of the spine
Lumbar	- The part of the spine between the ribs and the pelvis
Malunion	- Union of a bone in faulty position
Manus Valga	- Deformity of the hand curving toward the little finger (clubbed hand)
Manus Vara	- Deformity of the hand curving toward the thumb (clubbed hand)
Metatarsalgia	- Pain in the anterior arch of the foot
Metatarsus Varus	- Pigeon-toes
Muscular spasm	- A spasm of a muscle
Myositis	- Inflammation of a muscle
Myositis ossificans	- Bone tissue growing in a muscle
Myotomy	- Cutting a muscle
Myotonia	- A disorder characterized by temporary rigidity of the muscle
Myxedema	- A hardening of the skin, loss of hair, and peculiar phenomena due to a deficiency of the thyroid gland
Necrosis	- A local death of tissues
Neuralgia	- Irritation of a nerve
Neuritis	- Inflammation of a nerve
Neuroma	- A tumor of a nerve
Neurotomy	- Cutting into a nerve
Osteo-arthritis	- Inflammation of the articular extremity of a bone in which new bone is produced in the joint
Osteochondritis	- Inflammation of bone and cartilage
Osteogenesis	- The production of bone
Osteoma	- A bone tumor of nonmalignant character
Osteomalacia	- A disease characterized by gradual softening and bending of the bones
Osteomyelitis	- An infection of the bone
Osteoporosis	- Absorption of bone salts. Wasting away of bone tissues
Osteosclerosis	- Hardening of the bone
Osteotomy	- The breaking of a bone by instruments or by hand
Paraplegia	- Paralysis of both lower extremities
Pathologic	- Material changes in the body as the result of disease or injury
Periarthritis	- Inflammation of the parts surrounding a joint

Periosteum	- Membranous covering of a bone
Poliomyelitis	- Infantile paralysis
Polydactylism	- More than five fingers or toes
Pronation	- Rotation of the arm so that the palm is downward
Pseudarthrosis	- A false joint
Pseudohypertrophic	- An enlargement of a part due to elements other than of that part
Pseudoparalysis	- Apparent paralysis - but not really due to a lesion of the nervous system
Rachitic	- More commonly termed rickets. A softening of the bone
Rotation	- Turning or moving a part of the body on its axis
Sciatica	- A painful disturbance of the sciatic nerve
Scoliosis	- Curvature of the spine
Spastic	- Muscular rigidity or resistance to movement
Spondylitis	- Inflammation of a vertebra
Spondylolisthesis	- Forward displacement of a vertebra
Still's disease	- A form of joint inflammation in children in which many joints are swollen and glands are enlarged
Subluxation	- An incomplete dislocation
Suppuration	- Presence of pus in a wound
Syndactylism	- Fingers or toes that are grown together
Synovectomy	- Removal of synovial membrane
Synovial fluid	- Secretion of the synovial membrane in a joint
Synovial membrane	- The lining of a joint
Synovitis	- Inflammation of synovial membrane
Talipes	- A deformity of the foot
Tenosynovitis	- Inflammation of synovial membrane of a tendon
Tenotomy	- Cutting of a tendon
Torticollis	- A distortion of the neck in which the head is pulled to one side
Traction	- To pull or draw on a part as in the splinting of fractures or displacements
Trauma	- Injury to a part
Valgus	- A deformity in which the part turns outward as in knock-knee or flat feet
Varus	- A deformity in which the part turns inward as in bowleg or club foot

Visual terminology

Accommodation	- The power of the eye to alter its focus and see clearly at different distances
Amblyopia	- Dimness of vision without apparent disease
Ametropia	- Refractive defect
Aphakia	- Absence of lens
Aqueous	- Clear, watery fluid which fills the anterior and posterior chambers within the front part of the eye
Asthenopia	- Eye strain
Astigmatism	- A defect of vision preventing proper focusing
Blepharitis	- Inflammation of the margin of the lid
Canthus	- The angle at either end of the slit between the eyelids
Cataract	- Partial or complete opacity of the crystalline lens or its capsule
Central Visual Acuity	- Perception of objects in direct line of vision
Choroid	- Vascular membrane just over the retina which furnishes nourishment to the eyeball
Cilia	- Eye lashes

Conjunctiva	- Mucous membrane which lines the eyelids and covers 1/3 of the anterior portion of the eyeball
Conjunctivitis	- Inflammation of the conjunctiva
Convergent squint	- Crossed eyes
Cornea	- (Window of the eye) Curved, transparent, tough tissue covering front of eye, protecting it but allowing light to pass through
Diopter	- Unit of measurement of strength or refractive power of lenses
Diplopia	- Double vision
Disc	- (optic) The circular area in the retina that represents the termination of the optic nerve.
Dislocation of lens	- Displacement of lens from the natural position
Divergent Squint	- Wall eye
Ectropion	- Eversion of the eyelid
Emmetropia	- Normal refraction
Entropion	- Inversion of the eyelid
Enucleation	- Complete surgical removal of the eyeball
Esophoria	- A tendency of the eye to turn inward
Esotropia	- A manifest turning inward of the eye (crossed eye or convergent strabismus)
Exophoria	- Tendency of the eye to turn outward
Exotropia	- A manifest turning outward of the eye
Exophthalmus	- Abnormal protrusion of the eyeball
Field of Vision	- Entire area which can be seen without shifting the gaze
Focus	- Point to which rays are converged after passing through lens
Glaucoma	- Increased intraocular tension of the eye resulting in hardening of the eyeball
Glioma	- A malignant tumor of the retina
Hemianopsia	- Blindness of 1/2 the field of vision, of one or both eyes
Hordeolum	- Stye
Hyperopia	- Far sightedness
Interstitial Keratitis	- Inflammation of the cornea usually due to congenital syphilis
Iris	- A colored membrane, circular in form, suspended behind the cornea, just in front of the lens and perforated in the center by a round hole called the pupil, which regulates the amount of light entering the eye by changing the size of the pupil
Iritis	- An inflammation of the iris
Keratitis	- An inflammation of the cornea
Lacrimation	- Tearing
Lens	- Transparent structure behind the pupil which focuses light rays on the retina
Leukoma	- A white scar on the cornea
Macula	- A small area in the center of the back portion of the eye where vision is most distinct
Myopia	- Nearsightedness
Needling	- An operation for the removal of a cataract by piercing the lens capsule and allowing the lens material to be absorbed into the eye
Nyctalopia	- Night blindness
Nystagmus	- Involuntary back and forth movement of the eyeball
Oculist	- Eye physician (same as ophthalmologist)
Oculus Dexter	- (O.D.) right eye
Oculus Sinister	- (O.S.) left eye
Oculus Uterque	- (O.U.) both eyes
Opacity -	- Condition of being impervious to light
Ophthalmia	- Inflammation of the eye or of the conjunctiva
Ophthalmia Neonatorum	- Acute purulent conjunctivitis in the newborn

Ophthalmologist	- One who has studied the science of ophthalmology, an eye physician (same as oculist)
Optic	- Pertaining to vision or to the science of light
Optic Atrophy	- Atrophy of the optic nerve
Optic Nerve	- Second cranial nerve - special nerve of the sense of sight
Optician	- One who makes, mounts, and adjusts glasses according to prescription of an eye physician
Optometrist	- A non-medical person who specializes in correcting refractive errors by fitting glasses
Orbit	- The bony cavity which surrounds the eyeball
Orthoptic Training	- Specially planned exercises for developing or restoring normal teamwork of the eyes
Palpebral	- Pertaining to the eyelid
Photophobia	- Abnormal sensitivity to light
Phthisis Bulbi	- A shrunken eyeball which is totally blind
Pink eye	- Acute epidemic conjunctivitis
Presbyopia	- "Old age" vision. Loss of accommodation
Prosthesis	- Replacement of a human eye by an artificial one
Pterygium	- A triangular fold of membrane extending from the outer portion of the conjunctiva toward the cornea
Ptosis	- A paralytic drooping of the upper eyelid
Pupil	- The round hole in the iris which allows light to pass through to the inner part of the eyeball
Refraction	- The testing of eyes to determine whether glasses are necessary
Refractive Error	- A defect of the eye that prevents light rays from being brought to a single focus exactly on the retina
Retina	- The innermost coat and perceptive structure of the eye formed by the expansion of the optic nerve
Sclera	- The white portion of the eyeball. A membrane which with the cornea forms the external protective coat of the eye
Strabismus	- Crossed eye
Stye	- An acute inflammation of the edge of the eyelid
Tension	- (intraocular) The amount of pressure of the contents of the eyeball
Tonometer	- An instrument for measuring tension
Trachoma	- A contagious disease of the eyelids characterized by small granular-like elevations on the conjunctiva, later by cicatricial contraction and deformity of the lids. (a chronic form of infectious conjunctivitis)
Trichiasis	- Inversion of lashes
Uvea	- Entire vascular coat of the eyeball consisting of iris, ciliary body, and choroid
Vascular Coat	- (uveal tract) the middle coat of the eye; the structure that carries the blood vessels that nourish the internal structure of the eye
Vitreous	- Substance resembling white of an egg which fills the space back of the lens and maintains the shape of the eye

Abbreviations and signs used in Ophthalmology

A. or Acc.	- Accommodation
Am.	- Ametropia
As.	- Astigmatism
As.H.	- Hyperopic astigmatism
As.M.	- Myopic astigmatism
Ax.	- Axis of lens

D.	-	Diopter
F.	-	Field of vision
M.	-	Myopia
O.D.	-	Right eye
O.S.	-	Left eye
O.U.	-	Both eyes
P.O.	-	Perception of light
Pr.	-	Presbyopia
T.	-	Tension
V.	-	Vision of visual acuity
/	-	Convex
-	-	Concave
=	-	Equal to

J. GENERAL SANITATION

It is suggested that the nurse familiarize herself with the scope of the sanitarians' work. Where there is a common problem, service is greatly facilitated when the nurse and sanitarian work in close cooperation, e.g., typhoid, dysentery and tuberculosis cases

K. PROTECTION OF FOOD AND MILK

See General Sanitation

L. LABORATORY

1. Interpretations

DIPHTHERIA

I. "DIPHTHERIA-LIKE ORGANISMS WERE PRESENT" means that *Corynebacterium diphtheriae* was demonstrated culturally and microscopically, with or without admixture of other organisms. When others are numerous, their presence is noted.

II. "DIPHTHERIA-LIKE ORGANISMS WERE NOT PRESENT" means simply that *Corynebacterium diphtheriae* is not found in the specimen examined which may be due to:

- (a) Improper technique in applying swab. Considerable vigor should be used so that not only the prominent parts of the mucous membrane, but also the depressions and crypts, have been rubbed.
- (b) Some antiseptic may have been used prior to taking the specimen, or the patient may have been treated with an effective drug.
- (c) It is possible that a few *Corynebacterium diphtheriae* covered by a large number of other bacteria in the growth, may have been overlooked in examination.

IF CLINICAL SYMPTOMS CONTINUE SEND ANOTHER SPECIMEN.

III. No diagnosis may be given on account of non-development or scanty growth of culture.

In that case "NO GROWTH" or "SPECIMEN UNSATISFACTORY," is reported, and another specimen should be submitted.

SPUTUM

I. "No acid fast bacilli found" in the sputum of the patient suspected of having pulmonary tuberculosis may be explained by one of the following statements:

- (a) The disease is in an early stage before the tubercles have commenced to break down.
- (b) The avenues through which the bacilli pass from the active lesions into the sputum are temporarily occluded or have been closed by the process of tissue repair.
- (c) This specimen contained so few bacilli that they could not be found by the careful microscopic examination of several smears.
- (d) The specimen may be from the upper air passages.
- (e) The patient does not have tuberculosis.

DO NOT BE SATISFIED WITH ONE NEGATIVE REPORT. Send in other specimens and disregard all negative reports unless they are confirmed by repeated physical examinations and careful observations of the patient, including temperature records, over a considerable period of time. The culture method is more sensitive and will be performed upon request.

GNONOCOCCUS

A laboratory diagnosis of gonococcus infection is made upon the presence of Gram-negative, intracellular diplococci. A negative result may be due to any of the following causes:

- (a) The smear was not taken from the site of infection.
- (b) An antiseptic had been used just prior to taking the specimen.
- (c) An old chronic case in which microscopic picture is not characteristic.
- (d) When typical Gram-negative intracellular diplococci are reported, the interpretation must be based upon clinical history.
- (e) The patient may have been treated with an effective drug.

A SINGLE NEGATIVE REPORT IS OF SLIGHT DIAGNOSTIC IMPORTANCE.

TYPHOID

The blood culture is the procedure of choice as an aid to the diagnosis of typhoid fever during the first ten or twelve days of the disease. Jars suitable for such blood cultures are sent to physicians upon request. After the patient has been ill more than eight days, blood may be submitted for a Widal test. Before this time the Widal test will give very little information. When whole blood is received, the clot will be cultured for the presence of organisms of the typhoid and para-typhoid group. Several days are required for completion of the culture. Therefore, the report on the agglutination test will be made in twenty-four hours, while the report on the culture will not be made until later. Two antigens are used in the Widal test: the alcoholic, or O, antigen, and the formalized, or H, antigen. Following is a suggested interpretation of results:

- (a) Alcoholic antigen positive in a serum dilution of 1/80 or higher.
 1. Patient has an infection with *Salmonella typhosa* or organisms with similar antigenic patterns.
 - (b) Formalized antigen positive in a serum dilution of 1/80 or higher.
 1. Patient possibly has infection with *Salmonella typhosa*.
 2. Patient has had such infection.
 3. Patient has been immunized.

An agglutination in a serum dilution of less than 1/80 is of little diagnostic value; however, the physician is urged to send specimens at frequent intervals until a diagnosis is made. A gradually increasing titer is of great diagnostic significance. Stool specimens may be used as an aid to diagnosis if carefully taken and sent to the laboratory immediately. The examination of stool and urine specimens is the only means available in detecting typhoid carriers.

UNDULANT FEVER (Brucellosis)

The laboratory may be of decided assistance in the diagnosis of undulant fever. Not less than 2 or 3 cc of blood should be sent and this should be taken after the eighth or ninth day of illness. Agglutination in a dilution of 1/80 is suggestive of Brucellosis and further laboratory procedures are indicated. A rise in titer is of diagnostic significance. Suitable containers will be sent to the physician if a blood culture is desired.

TYPHUS FEVER

Rocky mountain Spotted Fever

Weil-Felix demonstrated that proteus-like organisms were agglutinated in a high titer by the sera of the patients with typhus fever. Different strains of the organisms have been used, but the strain termed Proteus OX-19 is the one commonly employed. Recent studies by Davis (1935) indicate that the Proteus OX₂ type is of importance in the differential diagnosis of Rocky Mountain spotted fever and typhus fever. The Proteus OX₂ strain is agglutinated in a higher titer with sera from Rocky Mountain spotted fever patients than with sera from typhus patients.

An agglutination in a dilution of 1/80 or 1/100 is suggestive of a typhus, or Rocky Mountain spotted fever infection, but is not diagnostic. It is advisable to obtain a specimen as soon as symptoms develop, again in about ten days, and a third in about ten more days. A rise in titer during the infection and a fall during convalescence is definite evidence of infection.

TULAREMIA

Laboratory test must be requested on card.

2. Storage of laboratory containers

- a. Wassermann, Widal, G.C., T.B., and water containers, also diphtheria containers carrying swabs only, may be held indefinitely if containers are not opened. All opened containers should be returned to the Laboratory
- b. Feces bottles may be held as long as the clear liquid remains clear. If the liquid becomes turbid, return to the Laboratory at once
- c. Diphtheria kits should be stored in the refrigerator and should be returned as soon as the media looks dry or when molds appear on the media

3. Collection of specimens

- a. Technique for taking nose and throat cultures for diphtheria
 - (1) Secure district health officer's instructions for type of culture to be made on cases and contacts
 - (2) Use dry swab technique for survey or casual contacts
 - (3) Home visit
 - (a) Follow suggestions regarding communicable disease isolation technique
 - 1) Make set-up at bag on paper napkin
 - 2) Make a second set-up of mailing laboratory containers or culture kit
 - a) Place mailing containers open on napkin at the bag, and paper in which tubes and vials are wrapped. Corner turned back
 - (4) Equipment
 - (a) Contents of mailing tube container -
 - 1) 1 test tube labelled "Nose" - 2 sterile swabs
 - 2) 1 test tube labelled "Throat" - 2 sterile swabs
 - 3) 1 tongue depressor
 - (b) Contents of diphtheria kits
 - 1) 2 vials of Loeffler's media
 - 2) 2 vials of tellurite media
 - 3) 2 tubes containing sterile swabs
 - 4) 1 tongue depressor in cellophane wrapper
 - (c) Flashlight
 - (d) Waste bag
- (5) Procedure
 - (a) Complete data on laboratory card at bag
 - (b) Wash hands
 - (c) Carry culture set-up to patient area
 - (d) Have attendant or member of family hold flashlight in proper position
 - (e) Make a thorough inspection of throat before taking culture

- 1) Determine site of most severe infection
- (f) Remove sterile applicator from tube, depress tongue, swab over white spots or inflamed area on tonsil or uvula. Remove portion of membrane if possible
- (g) If throat swab is to be applied to media, hold vial or tube so moisture rises over slant surface. Rotate swab between thumb and forefinger as it slides back and forth over the media. Be careful not to break the surface. Press swab against glass inside the tube or vial to express excess moisture. Remove swab and return to tube
- (h) Replace vial cap straight and firm but not too tight. Insert cotton plug in tube with swab
 - 1) Prevent contamination of cap or cotton plug
- (i) If culture is to be planted on media in the laboratory, swab throat as in #7, and replace contaminated throat applicator in tube labelled "Throat"
- (j) Nose - remove sterile applicator and insert swab in both nostrils. Insert to nasal pharynx and rotate gently. (If much nasal discharge, have patient blow nose before taking culture)
- (k) If swab is to be applied to media, use the same method as for throat culture #7 and replace in tube labelled "Nose"
- (l) If culture is to be planted on media in laboratory, use the same method as in #10, and replace contaminated swab in tube labelled "Nose"
- (m) Wash hands
- (n) Remove apron
- (o) Carry test tubes or vials and tube containing used swabs, and place on original wrapping paper at the bag
- (p) Wash hands
- (q) Without touching test tubes or vials, insert turned back corner of wrapping paper between test tubes. Wrap tightly in paper and insert in inner container
- (r) Wrap laboratory card around inner container and insert in mailing tube
- (s) Send to laboratory as soon as possible
 - 1) If a telephone or telegraphic report is requested, authorization to make call or telegraph "Collect" should be written on the laboratory card
- (t) Virulence tests may be requested for release of
 - 1) a case - whenever a case has been in isolation three weeks or more with persistent diphtheria like bacilli

- 2) Persistent carriers at end of three weeks
- b. Feces and Urine
- (1) Technique for collecting stool specimens for typhoid fever and dysentery cases, carriers, and contacts
 - (2) Technique for collecting urine specimens for typhoid fever cases, carriers and contacts
 - (a) Home visit
 - 1) Follow suggestions regarding Communicable Disease Isolation Technique
 - a) Make set-up at bag on paper napkin
 - b) Fill out laboratory card completely, and leave beside containers (1 for urine and 1 for feces)
 - c) Place two open laboratory mailing tubes and containers at the bag
 - d) Make set-up of listed equipment on napkin to take to patient's area
 - 2) Equipment
 - a) Contents of two laboratory mailing tubes
 - (1. Metal container
 - (2. Bottle one-fourth full of formalin solution
 - (3. Directions for collecting
 - b) Laboratory card
 - c) Clean bedpan or substitute. (Chlorine solution must be completely removed) (Suggest cardboard carton)
 - 3) Procedure
 - a) If a patient has diarrhea, no cathartic is needed
 - b) If patient does not have diarrhea, upon written order of the attending physician, patient should be given a cathartic the night before taking the specimen. (Magnesium sulphate is usually the first choice since it empties the gall bladder)
 - c) Collect urine specimen in clean bedpan or substitute
 - d) Add urine to solution in bottle for urine specimen to about three-fourths full. Replace cover tightly and mix solution and urine by shaking
 - e) Collect feces specimen in clean bedpan or substitute. (The specimen should be collected from the second stool after cathartic is given)
 - f) With tongue blade scoop up amount equal to, but no larger than a bean, of soft part of feces into solution in bottle marked feces
 - g) Replace cover tightly and mix solution by shaking
 - h) Wash hands
 - i) Remove apron
 - j) Carry specimens to bag set-up and place in container

- k) Wash hands
- l) Place container and laboratory card in mailing tube. Instruct as to disinfection of stool after specimen is taken
- m) Pack securely - mail immediately

c. Sputum

- (1) Instruct patient to collect specimen as follows
 - (a) Sputum should be collected in the clean, wide-mouthed jar with a tight cover that is supplied in the container. Purulent, cheesy, or mucopurulent sputum, preferably that coughed up from the lungs early in the morning, is the most satisfactory specimen. The presence of saliva, mucus, blood or food particles in the specimen is undesirable for reliable examination. To prevent the inclusion of such material, rinse the mouth with clear water. This may be accomplished by taking clear water in the mouth and discarding just before coughing to raise the material from the lungs
 - (b) If the jar is less than half full as the result of the first collection, the partially filled jar should be held until the second or even the third morning, each day adding to the jar the material raised as the result of coughing in the morning. When the specimen is satisfactorily collected, screw the cap on the jar and return the filled jar to the inner tin container. The white card should have the patient's and physician's name and address plainly written in the proper space. Information should be given as requested on the card. The physician should check the examinations desired. A direct examination is made on each specimen, and the culture and animal inoculation are performed when requested by the physician. The two latter examinations should not be checked unless the information so obtained is needed as an additional aid to diagnosis or check on treatment. When the card is completed, wrap it around the tin container holding the jar and place in the mailing container. DO NOT PLACE THE CARD NEXT TO THE JAR CONTAINING THE SPECIMEN
 - (c) At least one culture or animal inoculation, if possible, should be required on all negative sputa to determine whether or not acid fast bacilli are present

d. Stomach lavage

- (1) Special containers will be dispensed for collecting stomach lavage. This type of specimen should be collected in the morning before food is taken. When the stomach tube is in place, attach funnel and pour 100 to 300 cc. of warm, clear water into

the stomach. After the water is successfully placed in the stomach, remove by means of suction into the container supplied and send to the laboratory as soon as possible

(2) Complete the laboratory card

e. Serology tests

(1) It is recommended that nurses obtain medical orders to cover the following procedures

(2) Prepare equipment as outlined in Venereal Disease Manual, Page 9

(3) Containers

(a) Syphilis

1) Use prepared container and specific form from the State Laboratory

(b) Agglutination tests

1) Use Widal container and specific card

a) Typhoid

b) Typhus

c) Undulant fever (Brucellosis)

d) Tularemia (must be requested on card)

e) Other - according to medical orders

f. Smears

(1) Eye

(a) Equipment

1) Two clean slides

2) Heavy paper square for wrapping slides

3) Laboratory slip

4) Sterile cotton applicators (two)

5) Waste bag

6) Wax pencil

(b) Procedure

1) Home visit

a) Use approved bag technique and make set-up of listed equipment on napkin
(1. Slides may be marked before leaving office and clean sides placed together)

2) Office visit

a) Have listed equipment available

3) Technique for home and office visit

a) Mark slides with wax pencil - R for right eye, L for left eye

b) Wash hands

c) With thumb and first finger of one hand, hold eye open. With sterile applicator in other hand, swab over the surface of the lid collecting discharge

d) Rotate applicator gently over the slide. Place slide on wrapping paper

- e) Allow slide to dry
 - (1. Place slide with specimen side up.
Fold corner of brown paper to protect specimen
 - (2. Place second slide with specimen down, on top first slide
 - (3. Wrap together
 - (4. Wash hands
- f) Send to laboratory in protective container

(2) Malaria

(a) Equipment

- 1) Three clean slides in malaria container
- 2) Heavy paper square for wrapping slides
- 3) Laboratory slip
- 4) Sterile cotton applicator
- 5) Sterile needle or lancet on gauze square
- 6) Cotton balls - two alcohol and two dry
- 7) Waste bag

(b) Procedure

- 1) Home visit
 - a) Use approved communicable disease bag technique and make set-up of listed equipment on napkin
 - b) Slides may be prepared before leaving office. Put clean sides together in paper
- 2) Office visit
 - a) Have listed equipment together
- 3) Wash hands
- 4) Preparing the thick smear
 - a) It is essential that the blood be free from dirt coming from the skin, from dust or other debris
 - b) Cleanse the skin with alcohol and gauze or cotton and rub dry, or let the alcohol evaporate. (Alcohol on the skin or needle will "fix" the red blood cells)
 - c) Prick the skin deeply enough (preferably using the second or third finger of either hand) to allow the blood to well up in a large drop under gentle pressure but not deeply enough to cause excessive bleeding
 - d) Wipe off the first drop thus secured with DRY gauze or cotton
 - e) By pressure cause another drop to well up from the wound
 - f) Pick up the slide carefully between thumb and first finger and touch it, near the end, to the drop of blood, being careful to avoid actually touching the skin

- (a. In this manner secure three drops of blood fairly close together
- g) Then with an applicator stick or the corner of another slide, spread the three drops of blood into a smear with a rotary motion until a blood smear about the size of a dime or slightly larger, is obtained
- h) Allow the blood to dry in the air, slide flat so that the blood will be evenly distributed
- i) During the drying process take care to protect the blood smear from flies, dust, etc.
- 5) Preparing the thin smear
 - a) After making the thick smear, wipe the finger dry with DRY cotton or gauze
 - b) By applying gentle pressure cause another drop of blood to well from the puncture
 - c) Touch slide near the end, to the drop of blood, securing only ONE drop on the slide
 - d) Turn the slide right side up and hold it in a horizontal position between thumb and forefinger of the left hand
 - e) Take up another slide in the right hand, and touching the narrow edge at about a 45 degree angle to approximately the middle of the first slide, draw it backwards until it touches the drop of blood on the slide
 - f) Slightly raise the edge so that, by capillary action, the drop of blood will flow along the entire edge of the slide
 - g) With a quick forward motion, spread the blood thin along the entire surface of the slide. (This technique is identical with that involved in preparing a blood smear for a "differential" blood count) It is desirable that a thin smear be obtained, but uniformity and evenness are also important
 - h) Dry slide
 - i) Turn corner of paper and protect slide, first slide face up, second slide face down. Slides not touching
- (3) Other smears
 - (a) Gonorrhea
 - 1) Nurse may set up following directions given in the Venereal Disease Manual
 - a) The physician makes the vaginal and cervical smear*

*New Mexico Department of Public Health, Division of Venereal Disease Control, Division of Public Health Laboratory, "Recommended Procedure for Taking Smear Used As An Aid in the Diagnosis of Gonorrhea," April, 1944.

- (1. Vaginal smears do not necessarily constitute conclusive evidence either of infection or absence of infection
- (2. Nurse prepares slides as directed under (1) Eye Smears

M. MENTAL HEALTH SERVICE

1. Purpose
 - a. To give diagnostic service, treatment therapy and conduct an educational program
2. Program
 - a. State Guidance Clinic at Santa Fe, by appointment
 - b. Field work in state, as program is developed
 - c. Institutes, staff education, etc.

PART V

TECHNIQUES

- A. BLOOD PRESSURE
- B. FROZEN SYRINGES
- C. VISION TEST AND EYE INSPECTION
- D. HEARING CONSERVATION PROGRAM
- E. STANDING ORDERS
- F. STERILIZATION
- G. THERMOMETER TECHNIQUE
- H. URINE SPECIMEN
- I. UNINALYSIS TESTING TECHNIQUES

PART V - TECHNIQUES

A. BLOOD PRESSURE TECHNIQUE

1. Definition of blood pressure

"The pressure or tension of the blood within the arteries, maintained by the contraction of the left ventricle, the resistance of the arterioles and capillaries, the elasticity of the arterial walls, and the condition of fluidity of the blood. The systolic or maximum blood pressure is that occurring at the moment of ventricular systole. The diastolic or minimum blood pressure is that noted during the ventricular diastole immediately preceding the systole."*

2. Apparatus

- a. Mercury manometer
- b. Aneroid or spring type manometer
- c. Stethoscope (used in the auscultatory method). Careful observation of specific instructions regarding the handling and upkeep of the instrument is one of the main factors in obtaining accurate blood pressure readings
- d. ~~Paper~~ napkin

3. Methods

- a. With either type of manometer, two methods may be used
 - (1) The palpatory method is taken by the fingers at the radial artery at the wrist and measures only the systolic blood pressure
- b. The auscultatory method is taken with the bell of the stethoscope on the brachial artery at the bend of the elbow and measures both the diastolic and systolic blood pressure
 - (1) Cleanse stethoscope with alcohol sponge

4. General Procedure

In using either method certain details of technique must be used to insure accurate readings

- a. Explain what is being done - and why
- b. Have patient in a sitting or recumbent position. The same position and preferably the same arm at each reading
- c. Have the arm at ease, well supported, no constriction of clothes, and no tension or gripping
- d. Have the patient relaxed mentally and physically. The nurse should be free from tension, in a sitting position, with a good vision of the reading surface of the dial

5. Specific Procedures

- a. The rubber compression bag must be completely deflated and in correct position within the cloth arm band

*Widenius, Irja E. M.D., Gould, Sarah Ward, R.N., Blood Pressures in Maternity Care, Public Health Nursing, May, 1946, No. 5, pp 224-225.

- b. Wrap the cuff, protected by a paper napkin, smoothly around the upper arm with the lower edge of the cuff no less than two inches above the bend of the elbow
- c. Feel the radial pulse and count
- d. Inflate the arm band slowly until the radial pulse is no longer palpable then inflate the cuff about 10 mm. above that point
- e. Place the stethoscope a trifle above the crease in the elbow and slightly toward the inner aspect of the arm
- f. Allow the air to escape slowly from the cuff
- g. Listen for the first sound. This will be the reading of the systolic pressure
- h. Continue slow deflation and listen for the change from a clear sound to a dull and muffled sound. This will be the diastolic pressure. The diastolic pressure is read at this sound and not at the sound just prior to the disappearance of the sound. (If there is a difference between that point and the level at which the sounds completely disappear, the American Committee of the American Heart Association recommends that the latter reading should be regarded also as the diastolic pressure recorded in the following form: right arm or left arm , 140/80-70 or 140/70-0. If these two levels are identical, the blood pressure should be recorded as follows - 140/70-70.)
- i. Deflate the rubber compression bag completely
- j. Remove arm band
- k. Record

6. Blood pressure readings in antepartal and postpartal periods

- a. The normal range in the upper limits is 130-140 mm. systolic and up to 90 mm. diastolic
- b. The normal range in the lower limits is 90-100 mm. systolic and 60-70 mm. diastolic
- c. The following factors influence blood pressure readings
 - (1) Emotional strain
 - (2) Acute or chronic diseases
 - (3) Physical pain
 - (4) Fatigue
 - (5) Faulty diet and elimination

7. Alteration in arterial blood pressure

- a. The concensus, under basal conditions, is that the normality in blood pressure varies from 90 to 120 mm. systolic, and 60 to 80 diastolic with daily and yearly variations of from 5 to 10 mm.
- b. Report any deviation in blood pressure from above normal limits to physician immediately and any signs or symptoms of the clinical picture that might indicate need for medical attention

B. AID FOR FROZEN SYRINGES*

"It is of pertinent interest that glycerin should find such important uses in the care and recovery of all glass hypodermic syringes. For example, if glass surfaces of syringes have become 'frozen' or locked these valuable instruments need not be discarded. Very often the plunger can be separated by merely boiling the frozen syringes in an aqueous solution containing 25 per cent of glycerin, as recommended by one of the leading manufacturers of these essential hospital and nursing items.

"Of course, glycerin is an excellent preventive against syringe 'freezing' during storage and it has the advantage that it can be washed away with water before sterilization or use. Indeed, lubrication and sterility can be achieved in one simple method.

"According to Tomb, a British authority, a mixture of equal parts of 90 per cent alcohol and glycerin of phenol (equivalent to Glycerite of Phenol U.S.P.) forms safe and effective means of storing syringes that have been sterilized by boiling. Tests have confirmed both the safety and efficacy of this procedure. When the syringe is taken out of this mixture, the alcohol evaporates quickly, leaving behind a thin film of glycerin of phenol which serves not only to keep the interior of the barrel sterile but also prevents the piston from sticking."

C. VISION TEST AND EYE INSPECTION

1. For screening procedures, see New Mexico School Health Manual for Elementary Teachers p. 38 to 41

D. HEARING CONSERVATION PROGRAM AND PURE-TONE AUDIOMETER TESTING TECHNIQUES

1. Objectives

- a. To ascertain the pupil's hearing ability
- b. To discover ear conditions which need medical attention
- c. To aid in obtaining adequate examination and treatment
- d. To provide for the proper adjustment of the child and his school program
- e. To educate parent and child regarding proper care of the ears

2. Method of Procedure

- a. Audiometer test (Group - Grades, suggest, Pre-first, 1 - 3 - 7, by Pure-Tone Individual Test.) (Demonstrate to groups of 100 students or less)

*"The Army Nurse", September 1944, pps. 16 and 17

- (1) Pupils to be tested: (List to be prepared by principal)
 - (a) All $8\frac{1}{2}$ to $9\frac{1}{2}$ year old pupils who have not had the audiometer test
 - (b) All pupils above the age of 2nd and 6th grades, who have been failing in their work without a known explanation; and all pupils whom the teacher believes have hearing difficulty
 - (c) All ungraded and special groups who have never had this examination, who are nine years of age or over
 - (d) Ear cases selected by the teacher, school nurse or the school physician (To be tested each year)
 - (e) All pupils above the age of $8\frac{1}{2}$ to $9\frac{1}{2}$ who have missed the test, either because of absence, change of schools, or for any other reason. Each child should have a hearing test before leaving the elementary school. Teachers and nurses should check carefully. This information will be found on the back of the Cumulative Health Record
 - (f) All kindergarten or pre-first children. (Those who fail - retest each week for 5 to 6 weeks)
 - (g) All children with speech defects
 - (h) All children who fail daily assignments
 - (i) All children who spell poorly in comparison with others of same grade
 - (j) All children who have poor reading or poor language ability
 - (k) All children who are inattentive or dreamers
 - (l) All problem children
 - (m) All children who like to sit on the back seat
 - (n) The child who has just returned to school following an infectious disease
- (2) Superintendents and principals should understand and appreciate the program first. Their co-operation is necessary in planning for
 - (a) Parents and community participation
- (3) Advance notice to principal by audiometer technician
 - (a) Date and time of test
 - (b) Details of procedure
- (4) Advance notice to nurse by audiometer technician
 - (a) Date and time of test
 - (b) Details of procedure
- (5) Preparation by nurse
 - (a) Consult principal regarding pupils to be tested
 - (b) According to above classifications add the following to principal's list
 - 1) Names of pupils who have developed a possible hearing problem since last visit of nurse
 - 2) Names of pupils who were found by otologist to be ear cases last year

Note: These names to be kept on family service record

- (c) Remind principal that each pupil in elementary school, who has not had an audiometer test, should be scheduled for same. Ask each teacher to make a survey of the Cumulative Health Records of her pupils and send to the principal a list of the names of those not having a record of an audiometer test
- (d) Notify teachers to send pupil's Cumulative Health Record to the testing room

Note: The audiometer technician records the hearing score for all normal cases on the Cumulative Health Record. She does not record the degree of hearing loss of im-paired hearing cases, but makes a notation "Refer to otologist"

Scoring of Hearing Test is done in decibels. A decibel is 1/10 of a bell, which is the unit of measuring the intensity of sound. For practical purposes decibels may be considered the same as per cent

A decibel loss of 10 or more in either ear is significant

3. Preparation

- a. Selection of room
 - (1) Must be a quiet location, away from corridors, street noises, and other disturbances
 - (2) Room should be equipped with a desk or table, two chairs, and electric outlet plug or socket within ten feet of the desk
- b. Provide supplies
 - (1) Alcohol
 - (2) Cotton
- c. Provide records
 - (1) Cumulative Health Record
 - (2) Pupil's Audiometer Test Record
 - (3) Referral to Parent
 - (4) Action Report, for physician
- d. Nurse
 - (1) Arranges audiometer demonstration to children in groups of 100 or less
 - (2) Nurse arranges for and instructs a pupil helper to bring the children to be examined
 - (3) Prepares a definite order of examination. Two or three pupils besides the one being examined should be in the room to observe and become acquainted with the fact that the examination does not hurt
 - (4) Records recommendations for correction of defects on Cumulative Health Record, and follows up these cases in the usual manner - Refer to private physician and/or otologist

(5) Follow-up to include

- (a) Audiometer demonstration to members of medical profession personally, in medical meeting
- (b) Office visit and/or home visit to parents of children with suspected defects
- (c) Office visit or telephone call to physician, regarding children being referred
- (d) Records on the Cumulative Health Record, the degree of hearing impairment as determined by otologist, following receipt of report

E. STANDING ORDERS

Upon approval of the local Medical Society, and the written order of the district health officer, the following standing orders may be used until specific order can be obtained from the attending physician, or in event the patient does not have an attending physician

1. General Suggestions

All standing orders are superseded by orders from the attending physician except communicable disease control measures as required in the regulations governing the Control of Communicable Disease, State of New Mexico, Department of Public Health

- a. Written orders shall be secured from the attending physician for all medication and special nursing care
- b. Verbal orders from the physician to the nurse shall be written on the service record and signed by the nurse. Written verification from the physician shall be secured as soon as possible
- c. Verbal orders transmitted to the nurse by the family should not be carried out until verified by the physician
- d. The Action Report form may be used. The physicians written orders should be attached to or written on the nursing record
- e. Two nursing visits may be made to sick persons not under medical care, this limitation, and the reasons for it, should be explained by the nurse on each of her visits. Temperature may be taken, the patient made as comfortable as possible, and emergency treatment according to authorized standing orders may be given. A record of care given should be made on the Action Report which is left for the physician or sent to him. Bedside nursing service may be given on a demonstration basis
- f. More than two visits by the public health nurse may be indicated to obtain desirable action in problems such as unsupervised maternal and child health, untreated or undiagnosed morbidity, tuberculosis, and the school age child. All contacts in the home and office afford an educational opportunity to stress the value of medical and dental supervision

- g. The public health nurse acts on direction of the district health officer
- (1) The Immunization Procedures, School Health Service-Standing Orders, in the "New Mexico School Health Manual for Elementary Teachers", Page 47, and the Dysentery Control Program, June 21, 1943, Suggested Method of Use of Sulfaguanidine, and other standing orders as approved, are to be used as standing orders for guidance in giving care and teaching
 - (2) Nurse may isolate quarantine and placard, complying with the Regulations Governing Control of Communicable Diseases. She may teach isolation of the case in accordance with techniques suggested in this Manual. Teach attendant or relative by demonstration how to carry out the physician's orders relative to the care of the patient
 - (3) Upon the written authorization of the district health officer, in isolated areas, when a communicable disease is suspected, and no physician is in attendance, the nurse may placard, isolate the patient, and quarantine the contacts, as required by the Regulations Governing the Control of Communicable Disease. In completing the communicable disease report card for the suspected disease, the nurse makes a notation of measures taken to prevent the spread of the disease. (See sample communicable disease card)
When instructed by the district health officer, the nurse may make a telephone report. This call is to be noted on record

2. Immunization Procedures

All immunizations are given to children only upon request from parent or guardian or in their presence. These procedures are carried out by a physician, or a nurse working on his direction

a. Equipment

- (1) A wood or metal box, Boston bag or other container with a handle, to carry material to be used
- (2) Immunization Record and Request Form
- (3) Service Record
- (4) Writing materials, pen, pencil, blotter and ink
- (5) Vim needle holder or wheel, stand and handle
- (6) Two Petri dishes
- (7) Hypodermic needles -
Size - 26 gauge, 3/4" length
27 gauge, 1/2" length
2 large needles for filling syringe
- (8) Acetone - chemically pure
- (9) Receptacle in which to boil needles and syringes
- (10) Heatabs or Sterno
- (11) Ampoules of adrenalin - 1:1000 in aqueous solution, furnished by the State Department of Public Health

- (12) Two 5 cc. syringes
- (13) One 2 cc. syringe with hypodermic needle for adrenalin - autoclaved
- (14) Cotton sponges - dry and alcohol
- (15) Aromatic spirits of ammonia
- (16) Newspaper bags for waste

b. Treatment for Reactions

- (1) A sterile syringe and needle reserved for this purpose and 1 cc. ampoule of adrenalin - 1:1000 in aqueous solution should always be available on the table on which the immunization materials are placed. If angioneurotic edema, asthma, severe urticaria, shock or other immediate reaction occurs following an immunization, the child should be given adrenalin intramuscularly in an extremity and the area massaged to facilitate absorption. If absorption appears too rapid, a tourniquet can be applied for a short time
- (2) Unless child is known to tolerate adrenalin well, start with 1/4 cc. followed by 1/2 cc. in ten minutes, if necessary. Some patients are allergic to adrenalin and even 1/4 cc. will produce a severe reaction
- (3) For adults, 1/2 cc. can usually be given safely, followed by 1/4 cc. or 1 cc. in ten minutes, depending upon patient's condition
- (4) Patients with immediate reactions should be watched for at least 45 minutes after the reaction has subsided and the patient's physician notified of the reaction

c. Diphtheria

(1) Products

- (a) Plain diphtheria toxoid (Ramon) - clear fluid - reject cloudy
Dose - 1/2 cc. - 1 cc.
1 cc. at intervals of one month
- (b) Alum precipitated toxoid - milky fluid - kept cold
Give at room temperature
Dose - First dose 1/2 cc. or 1 cc. depending on product used. Second dose 1 cc. three weeks to one month later. (From a public health point of view, a single dose of alum precipitated toxoid cannot be relied upon to produce immunity. This product is rapidly replacing all others. It is slowly absorbed and produces a higher degree of immunity)

(2) Ages

- (a) Between nine and twelve months of age and up to eight years of age
- (b) Repeat or booster dose on school entrance - 1 cc
- (c) If an infant under nine months of age comes to the clinic and there will be no opportunity to see the baby until after nine months of age, the first dose of alum precipitated toxoid should be given if six months or over

- (d) For individuals over eight years of age, and adults, immunizations will not be done routinely except at the discretion of the district health officer. For procedures applicable to these older groups, see the approved methods of the U.S.P.H.S., Public Health Reports, Reprint No. 1697, "Communicable Diseases", revised 1945
- (3) Techniques
- (a) Wash hands, cleanse top of bottle with alcohol sponge. Arrange needles and syringes on sterile towel or use needles arranged on wheel. Fill syringes with product being used. Cleanse area over insertion of deltoid with alcohol sponge. Inject deeply into subcutaneous tissue over the deltoid area. When removing needle, press area with sterile sponge
- (4) Reactions
- (a) Older children and adults may have local or general reactions from the product
- (5) Duration of Immunity
- (a) Variable. Two months after immunization 70 to 90 percent will be immune. One-third will have lost immunity after five years. It is important that with a single dose of alum precipitated toxoid 83 to 94 per cent are Schick negative two years after
- (6) Schick Test
- (a) From a public health viewpoint it is unnecessary to use the Schick test on young children. It may be used to determine the immunity status of a group. It should be used before the immunization of older children and adults
- (b) The Schick test, to determine immunity, consists of an intradermal injection in the forearm of 0.1 cc. of a toxin solution which has been diluted especially for this purpose
- (c) The results are read five days later. A red area over 0.5 cm. in diameter is a positive reaction and indicates susceptibility. A control test should be used when the results are to be read in 48 hours
- (d) Interpretation of Reactions as They Appear After the Schick Test
- 1) Negative
- Immune to diphtheria at the time of reading. No reaction is seen other than at the site of the needle puncture. When a control is used and the reaction is read at the end of 48 hours, there is a diffuse reddened area equal on both arms, which appears within 24 hours and is usually gone by the fourth day
- 2) Positive
- On the test arm, a red flush appears after 24 hours or 36 hours reaching the maximum on the fourth day. It becomes a circumscribed area not less than 1/2 cc. in diameter. It fades slowly leaving an area of brownish pigmentation

- 3) When a control is used no reaction is seen in the control area on the other arm

d. Smallpox Vaccination

- (1) Should be given to all persons. It should be done as early as possible preferably before the end of the first year. If 55 to 60 per cent of the population is protected, an epidemic is unlikely
- (2) Vaccine Must be Kept Constantly Cold
 - (a) A thermos jug or coffee can, surrounded by ice, or some other means of keeping cold can be used when traveling to remote sections of the county. Before using the vaccine, be sure that the expiration date has not been reached
- (3) Technique
 - (a) Wash hands, wipe tube of vaccine with an alcohol sponge and break both ends. Place the small rubber bulb on one end of the tube. Cleanse deltoid area of the left arm with an acetone sponge. Squeeze a drop of vaccine on the cleansed area. Grasp the under side of the arm so that the skin is tightly drawn. Press the needle against the skin through the drop of vaccine ten to twenty times, holding the needle parallel to the skin. Wipe off excess vaccine with a sterile sponge
- (4) Care of the Vaccination
 - (a) Instruct the patient to return in one week. NO SHIELDS OR DRESSINGS SHOULD BE PLACED OVER THE VACCINATION, NOR SHOULD POWDER, SALVE OR OTHER MEDICATION BE USED. A clean cloth may be sewed inside of the sleeve for protection
- (5) Types of Reactions
 - (a) Primary Take
 - 1) Called a "typical primary reaction" - starts on the fourth or fifth day and reaches peak on the tenth day. This individual is one in which an immunity is produced
 - (b) Vaccinoid or Accelerated Reaction
 - 1) Reaches peak in four to seven days. Indicates some immunity but not sufficient to protect completely against smallpox. Immunity is raised to a protective level by this procedure
 - (c) Immune Reaction
 - 1) Reaches peak in two days. Indicates immunity. Record date of vaccination, reaction, etc. The procedure raises the immunity to a protective level. Explain directions to the parents
 - (d) No Take
 - 1) The process should be repeated until a positive reaction is observed
- (6) Reading Reactions
 - (a) If an immune reaction is anticipated, read at two days. Record the reaction and the person need not be seen again

- (b) A vaccinoid reaction will not show at two days and the person should be seen five days later. Then the vaccinoid reaction will be near peak and the primary beginning
- (c) Primary reaction. See the person in nine to eleven days and observe the vaccination

(7) Duration of Immunity

- (a) Not reliable after five years in the presence of an epidemic
- (b) Five to seven years is the usual duration
- (c) Life time - occasionally
- (d) Brief time - rarely

• Typhoid Fever

(1) Should be used for individuals over two years of age under the following conditions:

- (a) When typhoid is epidemic in the community
- (b) Where the water supply is questionable and sewage disposal primitive
- (c) For travelers
- (d) For members of a patient's family
- (e) Institutional personnel
- (f) Persons living in an endemic area
- (g) Military

(2) Techniques

- (a) Cleanse the skin with alcohol or with soap and water. After insertion of needle into muscle tissues withdraw the plunger of syringe. If blood shows, choose another site
- (b) Use three subcutaneous doses - one week apart - for a primary immunization
- (c) Vaccinate only healthy individuals
- (d) Concentrate program on the most active population groups

(3) Dosage

- (a) Older Children and Adults
 - First dose - 1/2 cc.
 - Second dose - 1 cc.
 - Third dose - 1 cc.

- (b) Pre-school and Young Children - Dosage based on weight, amount estimated to the following age groups

First dose	-	1/4 cc.	or	1/5 of adult dose	for	2 to 4 yrs
Second dose	-	1/2 cc.	or	1/4 "	"	4 to 6 "
Third dose	-	1/2 cc.	or	2/3 "	"	6 to 8 "

(4) Duration

- (a) Protection may last a long time but it is often lost in 1-1/2 to 2 years
- (b) Adequate re-immunization can be obtained with a single dose instead of three doses of vaccine. It may be administered in two ways -
 - Subcutaneously - 0.5 cc.
 - Intradermally - 0.1 cc.

- (c) When using the intradermal method, a small raised area appears similar to the area shown in a Schick test procedure. This method is used only as a re-immunization dose, after the individual has had a complete series of three subcutaneous injections

f. Whooping Cough

- (1) Product
 - (a) Sauer's Vaccine
- (2) Dose
 - (a) According to instructions for product used. It is usually 1/2 cc. - 1 cc. - 1 cc. at three or four week intervals
- (3) Ages
 - (a) Third and Twelfth month
 - (b) It is important that all children under 1 year be protected first before immunization is offered to other pre-school children. The highest death rate is under one year
- (4) Exceptions to the above recommendations are
 - (a) Pre-school children who are frail or under par
 - (b) The cardiac pre-school child
 - (c) The asthmatic pre-school child
 - (d) Take precautions with the allergic child. A physician should always give this immunization
 - (e) These exceptions are only done with the approval of the district health officer or the physician. Adrenalin should be quickly available
- (5) Technique
 - (a) Wash hands and cleanse top of bottle with alcohol sponge. Arrange needles and syringes on a sterile towel or use needles arranged on wheel. Fill syringes with the required dose. Cleanse area over the insertion of the deltoid with an alcohol sponge. Inject deeply into subcutaneous tissue over the deltoid area. When removing needle, press area with a sterile sponge

g. Combined Whooping Cough and Diphtheria Immunization

- (1) If the district health officer has approved or recommended that perdipigen be used for combined whooping cough and diphtheria immunization, the following procedure has been suggested
- (2) Product
 - (a) Perdipigen
- (3) Procedure
 - (a) All children three months of age or over, to six years of age, who have had no immunizations or who have not had clinical whooping cough in definite form should receive three injections - 1 month apart - 0.2 cc, - 0.3 cc. and 0.5 cc. being the accepted dose of Squibbs "Perdipigen". (Combined whooping cough and diphtheria toxoid alum precipitated.) Where opportunity presents, the interval between injections may be 1 month or more
 - (b) Children who have definitely had whooping cough can be given diphtheria toxoid alum precipitated - two injections, with interval of two to four weeks or longer between

- (c) All children who give definite history of having had diphtheria and who have never been immunized subsequently should certainly be offered protection against whooping cough
- (d) Because of the high mortality of whooping cough in infants under one year, especially under six months, it is advisable to start immunizations at three months of age
- (e) Since in the combined vaccine the diphtheria protection is not as effective before nine months, we prefer to have additional booster doses given at nine months
- (f) Booster dose - 0.3 cc. - at nine months and at five or six years of age
- (g) If older children are immunized against whooping cough, all younger children in the family must be immunized
- h. When any other combinations including pertussis are used, follow the dosage directions on the box

3. School Health Service - Standing Orders
See New Mexico School Health Manual for Elementary Teachers, pages 47 - 52

Please note that supplementary standing orders are issued from time to time. Such orders must have local medical approval before adoption

4. Dysentery Control, Program

a. Suggested Method of Use

- (1) Infants - 1 year of age and under
Package 8 tablets sulfaguanidine 7.7 grains each, and write patient's name and the following instructions on envelope
"One-half tablet every 4 hours for 4 doses in 24 hours for 4 days"
- (2) Infants over 1 year of age and older children
Package 16 tablets sulfaguanidine 7.7 grains each and write patient's name and the following instructions on envelope
"One tablet every 4 hours for 4 doses in 24 hours for 4 days"
- (3) Amount of drug ordered and instructions on the envelope will be the same for treatment and attempted prevention

5. Suggested Treatment of Impetigo Neonatorum. (Taken from memorandum sent to all physicians in state by the Director, Division of Maternal and Child Health)

This suggested treatment is that outlined by Dr. C. Anderson Aldrich of the Mayo Clinic, Rochester, Minnesota, and it has been approved by the New Mexico Pediatric Society

- a. The treatment is as follows
 Immediate isolation, as soon as case is diagnosed. Give two doses of 5,000 units of penicillin at three hour intervals. Local treatment may or may not be used. The child may be returned to the ward thirty-six hours after the beginning of treatment
 - b. This method does not supplant good newborn nursery technique which should prevent the spread of impetigo if a case should occur in the nursery. Nursing techniques which prevent the spread of impetigo also prevent the spread of infantile diarrhea and other serious infections
 - c. This method does make the almost immediate control of impetigo possible and reduces the amount of time necessary to spend on special isolation and treatment of infants with impetigo, providing more nursing time for better nursing care of the infants in the newborn nursery
6. Impetigo (Contagiosa)(Yellow Crusts or Sores)
 Remove crusts by gently washing with warm water and soap. Then apply 10 per cent ammoniated mercury ointment to the sores twice daily
7. Ringworm
 Cleanse the spot with warm water and soap or hydrogen peroxide twice daily. Dry thoroughly. Then apply tincture of merthiolate and repeat until cured
8. Scabies
- a. Sulphur Ointment Treatment
 Take a hot bath using soap; scrub the parts thoroughly. Dry body and apply sulphur ointment. Put on clean underclothes. Each night before retiring, rub the body with sulphur ointment wearing the same underclothing to sleep in. Repeat this each night for six nights; then take a hot bath, using soap, and put on clean underclothes that have been boiled. Boil the underclothing, sheets, towels and washrags that have been used by the patient

 The sulphur ointment can be made by melting a teacup of lard and then stirring one heaping teaspoonful of sulphur in it while it cools
 - b. Burroughs Welcome Benzyl Benzoate Emulsion
 Cover the entire body with soft soap and work it into a lather with warm water. Scrub with soft nail brush, giving special attention to all parts of the body especially in the creases and between the fingers. The fingernails should be thoroughly cleaned

 Take a warm bath. Rub affected areas for ten minutes

Shake emulsion and apply vigorously with a brush while body is still wet. It is important that some of the emulsion penetrates under and around the fingernails. Allow to dry on body

Again apply emulsion vigorously. Remove excess with a towel and put on clothing worn before treatment

In 24 hours take another bath and dress in clean clothing

Discarded clothing, bed linen, towels, etc., should be boiled. Things that cannot be boiled should be put out in the sun

Apply Benzyl Benzoate again in 10 days

c. See DDT directions for use of - Number 10 - this section

9. Treatment for Head Lice (Pediculosis)

- a. Mix equal parts of kerosene and olive oil. (Wesson oil or Mazola may be used instead of olive oil). Rub this mixture into the hair and scalp thoroughly. Wrap head with cloth and leave on for eight hours or overnight. Then wash head thoroughly with soap and warm water. Dry the hair. Repeat this treatment on the next two days. KEEP AWAY FROM FIRE OR FLAME

(1) To Remove Eggs or Nits

After completing the above treatment, on the third day, wet the hair with warm vinegar. Leave on for half hour. Then brush the hair vigorously with a stiff brush, separating strands of hair and brushing upward on the other side, where the eggs collect. Pull off with fingers all eggs that do not brush out easily

The towels, sheets and pillowcases used by a person with head lice should be boiled, after treatment is completed, so as to kill eggs. The inside lining of hats and caps should be ironed with a hot iron to kill eggs

A person with head lice should never use another person's brush or comb

In order to prevent recurrence of lice in the hair, all persons in a family who are troubled with this condition should take the above treatment at the same time

- b. Use of McKesson & Robbins' Pyrinat A 200

This ointment should be thoroughly applied to the scalp and to the hair. After application the hair should be rubbed vigorously in all directions for a minute to insure thorough distribution, and thereby contact with the parasites and their eggs

After allowing the ointment to remain for at least 15 minutes, shampoo in the usual way, then comb the hair with a fine comb to remove the dead lice and eggs

Rinse thoroughly and dry in the usual manner

All clothes including bed clothes should be thoroughly sterilized by boiling in water

c. See DDT directions for use of - Number 10 - this section

10. DDT (Dichloro - Diphenyl - Trichloroethane)

Its use in the control of human scabies and lice

DDT is applied by the nurse, only under the written direction of a physician, and with written request from the parent. It is suggested that the following procedures be shown to the physician

a. Scabies

Infestation with the itch mite (*sarcoptes scabei*) can be controlled by use of DDT Emulsion (see formula given). The diluted concentrate (one part to five parts of water) should be applied by means of a sponge to the entire body with the exception of the head. Lesions should be given special attention. About two to three ounces per person per application are required. The treated individual should not bathe for at least 48 hours. In some cases a second application may be required in about seven to ten days

b. Head Lice

The head louse (*P. humanus humanus*) is easily acquired through exchange of combs, hats and from such places as infected beds and busses. Because of the ease of spread, head lice are often found among school children

When infestation of school children is suspected, head inspections should be made by the school nurse. DDT may be applied by her if she has written directions from the physician and written request of the parent

Method I

The use of a DDT dusting powder is especially applicable to individuals in homes or to small groups of school children. The following mixture should be prepared by a pharmacist

10 Per cent DDT Dusting Powder

DDT	10 parts by weight
Pyrophyllite (or powdered talc)	90 parts by weight

The hair should be well shampooed, to remove as much of the oil as possible, and allowed to dry completely before applying the dusting powder. The powder should be thoroughly and uniformly applied in such a manner as to penetrate to the scalp. Rubbing is usually necessary. A dusting can or small atomizer may be used. Care should be taken to prevent the dusting powder from entering the eyes

The hair should not be shampooed for at least 48 hours after DDT powder has been applied. If possible, keep the powder on the head for a longer time to prevent reinfestation and to kill the young lice on hatching from the eggs. DDT does not destroy ova. Dead lice may be removed the next day by combing the hair with a Derbac comb. A second application of DDT dusting powder 10 days after the first is recommended. Newly hatched lice are killed before they have time to lay eggs

A follow-up visit to the home, for inspection and DDT dusting of other members of the family may prevent subsequent reinfestation. Hats and other headgear should be dusted with DDT powder when indicated

Method II

The use of DDT in an emulsion is applicable where large numbers of children are to be treated. The following mixture should be prepared by a pharmacist

DDT Emulsion Concentrate	Benzyl Benzoate	68 parts by weight
DDT		6 parts by weight
Benzocaine		12 parts by weight
Tween 80 (emulsifying agent)		14 parts by weight

Dilute this concentrate one part to five parts of water before using. It is noninflammable

Apply by sprayer or by hand. Two to four teaspoonfuls is needed per individual depending on the amount of hair. Apply evenly and rub thoroughly into the hair since the eggs must be contacted to be killed. The eyes must be protected. This treatment destroys all lice and nits with a few hours and prevents reinfestation for two weeks if the head is not washed for 48 hours after treatment

c. Body Lice

The body louse (*P. humanus corporis*) is an important carrier of several diseases. It usually spends its life in the clothes of the individual but may lay eggs on the hairs of the body and is known to cling to the host when clothing is removed. In looking for body louse, one should examine clothing along the seams and folds. Control measures should be directed largely toward the treatment of clothing. Clothing should be treated with 10 per cent DDT dusting powder (10 per cent by weight of DDT in pyrophyllite) applied at the rate of one ounce of the powder to each individual's infested clothing.

Clothing should be treated with 10 per cent DDT dusting powder (10 per cent by weight of DDT in pyrophyllite) applied at the rate of one ounce of the powder to each individual's infested clothing. The entire inner surface of the underwear, including the seams, should be treated. Seams of other articles of clothing should also receive close attention

The above method will give protection from reinfestation of the treated clothing for three to four weeks. Although the powder is not ovicidal, newly hatched lice are killed by the residual action of DDT remaining in the treated clothes. The individual is not protected, however, if he changes to untreated, infested clothing

Impregnation of garments with DDT (2 per cent of the dry weight of the garment) is effective and gives a more permanent control of body lice than by the use of dusting powder. Treated garments worn continuously but washed once each week, are effective in eliminating lice for six to eight weeks (longer if not washed). Instructions may be obtained by writing to the United States Department of Agriculture, Bureau of Entomology and Plant Quarantine, Washington, D. C.

d. Crab Lice

The crab louse (*Phthirus pubis*) may be controlled by the use of a 10 per cent DDT dusting powder applied thoroughly and uniformly to all hairy areas of the body. About 10 grams per person per application is required. Since DDT is not ovicidal, the powder must be reapplied after an interval of seven to ten days. The individual should not bathe for at least 24 hours after application

DDT Emulsion (see formula above) is also effective against crab lice. The diluted concentrate (one part to five parts of water) should be applied thoroughly to all hairy portions of the body and be allowed to remain for 48 hours. One to two ounces per person per application is usually required. Unless all eggs are contacted by the first application, a second treatment will be necessary following an interval of 10 days

e. DDT Precautions

DDT is not a nontoxic substance. It is poisonous to warm blooded animals, including humans, when considerable amounts are ingested or absorbed through the skin

Care must be taken to prevent accidental ingestion by contamination of food since DDT is a white, odorless and tasteless powder, bearing a physical resemblance to flour. It offers no warning upon ingestion, DDT should never be stored with food products

Dry DDT in concentrated form or when used mixed with inactive powders, is not absorbed through the skin, but DDT in oils and organic solvents may be. Therefore, oily solutions of DDT should not be applied to the skin. (Shampooing of heads, before application of a DDT dusting powder is referred to in a preceding paragraph)

Eyes should be protected when DDT is being applied

For possible toxic effects resulting from the use of DDT in aerosols, and by other means of application not mentioned in this publication, reference is made to the extensive literature on this subject

Adapted from "A Manual for the Control of Communicable Diseases in California", California State Department of Public Health - 1948.

F. STERILIZATION INFORMATION

1. Method for using pressure cooker

- a. Allow cooker to steam out thoroughly until practically all of residual air has been forced out by the vaporized water before the stopcock or valve is closed. If this is done, dry goods, needles and instruments can be sterilized in 20 minutes at 20 pound pressure

2. Method of drying materials after pressure cooker sterilization

- a. For dry goods, needles and instruments, the valve can be opened as soon as heat is turned off, or at least within ten minutes, and allowing the enclosed steam or water vapor to escape. (This cannot be done with liquid materials)
- b. All materials, excepting rubber, can be laid in an oven with door left partly ajar, until dry

3. Boiling of hypodermic needles and syringes

- a. In low altitudes these articles can be sterilized by boiling three to five minutes. In high altitudes they must be boiled 15 to 20 minutes. (Boiling point 212° cannot be reached in high altitudes)

4. Length of time sterile gauze dressings may be kept before resterilization

- a. These may be kept indefinitely if they are left wrapped and do not become moist. Either brown paper or comparatively impervious cloth (e.g. muslin) are ample protection for sterilized dressings

Tested and approved by New Mexico State Public Health Laboratory, University of New Mexico, Albuquerque.

G. THERMOMETER TECHNIQUE*

1. It is advantageous to carry thermometers in uniform pocket during hot weather. Body heat will help regulate thermometer temperature and prevent breakage

a. Procedure for Care of Mouth Thermometer

- (1) Establish thermometer set-up on one corner of clean work area. Equipment as follows
 - (a) Thermometer and case
 - (b) Bottle of green soap
 - (c) Prepare 6 cotton pledgets - 3 water, 2 green soap, 1 dry - (Double number for communicable disease)
Water pledgets may be moistened at sink. Cup of water requested from family if no running water
 - (d) Return bottle of green soap and case to bag (optional)
 - (e) Close flaps
- (2) Taking the patient's temperature
Note
The pulse and respiration of children, patients with dyspnea (such as tuberculous, cardiac, etc.) should be checked before the temperature is taken. In other situations take pulse and respiration while thermometer registers
 - (a) Shake mercury below 96°
 - (b) Hold thermometer firmly at top with bulb down
 - (c) Lubricate with water pledget, one stroke down over bulb (hold pledget in hand)
 - (d) Place thermometer under tongue and leave for three minutes
- (3) Cleansing the thermometer
 - (a) Remove thermometer and wipe with the same moist pledget, using one downward rotary stroke with friction
 - (b) Hold thermometer bulb with moist pledget and read
 - (c) Hold thermometer with same moist pledget over paper bag and wipe with soap pledget, using one downward rotary stroke with friction
 - (d) Hold bulb with soap pledget
 - (e) Discard moist pledget
 - (f) Wipe thermometer with moist cotton pledget, using one downward rotary stroke with friction
 - (g) Hold bulb with moist cotton pledget
 - (h) Discard soap pledget
 - (i) Repeat cleansing steps from c. to h.
 - (j) Wipe with dry cotton pledget
 - (k) Shake thermometer down to 96°
 - (l) Place thermometer on dry cotton pledget on clean area or return to case if left out of bag
 - (m) Return thermometer to pocket or bag
 - (n) Record temperature, pulse and respiration (T.P.R.)

*Based on The American Red Cross Home Nursing Course - Unit I - Care of the Sick in the Home

b. Procedure for Rectal Thermometer

- (1) Same as for mouth thermometer except
 - (a) Substitute rectal for mouth thermometer
 - (b) Prepare 6 cotton pledgets - lubricant, 2 water, 2 green soap, 1 dry - (Use family oil to lubricate--
petroleum jelly, ~~vaseline~~, salad or mineral oil, saltless lard, etc.)
 - (c) Lubricate thermometer with oil pledget
 - (d) Insert in rectum and hold with pledget
 - (e) Leave for three minutes or until mercury remains stationary
 - (f) Cleanse as outlined for the mouth thermometer in #3
 - (g) Use letter R in recording rectal temperature

c. Procedure for Axillary Temperature

- (1) It is suggested that consideration be given to taking the temperature of children by axilla. Recommended by American Academy of Pediatrics - 1948* (Follow attending physician's orders)
 - (a) Use stubby bulb thermometer
 - (b) Prepare 6 cotton pledgets - 2 water, 2 green soap, 2 dry
 - (c) Remove shirt sleeve
 - (d) Wipe arm pit with dry cotton pledget
 - (e) Place dry thermometer in axilla, flex arm over chest to hold gently in place
 - (f) Hold thermometer in place until mercury remains stationary
 - (g) Cleanse thermometer as outlined under mouth thermometer #3
 - (h) Use letters Ax in recording axillary temperature

d. In Case of Communicable Disease - Refer to Communicable Disease Outline

- (1) Use mouth, rectal or axillary approved technique as outlined above
- (2) After cleansing at the patient's bedside or in his room, cleanse in the same manner at the bag set-up

H. URINE SPECIMEN

1. Clean specimen

a. Purpose

- (1) To obtain a urine specimen as free from extraneous material as possible without catheterizing the patient for microscopic examination or culture

b. Equipment

- (1) Basin of clean warm water, soap, and seven cotton pledgets
- (2) Bedpan
- (3) Newspaper
- (4) Newspaper bag
- (5) Roll of cotton wrapped in clean diaper or cloth
- (6) Covered glass container, for specimen
- (7) Paper napkin

*The American Academy of Pediatrics Committee on Fetus and Newborn -
Page 23

c. Procedure

- (1) Explain what is to be done to the patient in order to insure her cooperation and to allay fear
- (2) Cover chair seat with newspaper and place on it a basin of clean warm water with seven cotton pledgets; also newspaper bag, container for specimen, soap on saucer, paper napkin and roll of cotton
- (3) Place patient on bedpan and drape with sheet
- (4) Wash hands for two minutes
- (5) Without drying hands, wring out large cotton pledget and apply soap
- (6) With the thumb and middle finger of left hand separate the labia
- (7) With the soapy cotton wash the left labia with one downward movement; discard the cotton
- (8) Repeat, cleansing the right labia
- (9) With pledget wet with clear water rinse off left labia with one downward stroke; repeat on right side
- (10) Repeat if necessary using a separate cotton pledget for each downward stroke
- (11) Insert a moist cotton pledget well into the introitus
- (12) Place the glass container against the perineum and instruct the patient to urinate in the container; if this is difficult the patient may void directly into the bedpan and the specimen be poured from the bedpan into the container later
- (13) Remove the pledget from the introitus, dry the patient with cotton pledget from roll, remove pad from box and apply if needed, remove the bedpan and make the patient comfortable
- (14) Be sure outside of specimen container is dry; put it in a paper bag to take for microscopic examination; if gross examination is to be done in home, remove from container sufficient urine for the examination, and take the remainder to the clinic
- (15) Have the helper empty and wash the bedpan and replace it between papers under the bed
- (16) Empty and boil basin. Burn newspaper bag and contents
- (17) Record results of specimen examination on record

2. Collection of 24 hour specimen

a. Purpose

- (1) To calculate amount of albumin lost in 24 hours
- (2) To determine amount of concentration kidneys are able to effect
- (3) To measure total output for 24 hours

b. Equipment

- (1) Two, quart jars with lids
- (2) Measuring cup or #2 can which holds one pint
- (3) Boric acid powder - 1 teaspoonful
- (4) Pencil
- (5) Record as shown

c. Procedure

- (1) Wash jar and measuring cup well
- (2) Without drying the jar put into it one teaspoonful of boric acid powder
- (3) Place the jar and measuring cup near the bathroom or toilet in a place where the children will not disturb it
- (4) Put pencil and record in secure place
- (5) Instruct patient to
 - (a) On day when specimen is to be collected
 - 1) Void on arising (unless time is otherwise specified); do not save this urine
 - 2) Record exact time
 - (b) Save all subsequent urine excreted until the same time on the following day
 - 1) Suggestions
 - a) Measure urine
 - b) Place urine in the quart jars
 - c) Record on chart time of each voiding
 - (1) Exact time
 - (2) Amount
 - d) Record on chart intake of all liquids
 - (1) Time
 - (2) Amount
 - (3) Kind
- d. On the following day at the same hour as the first day collect, measure, record, and save urine
- e. Mix urine thoroughly
- f. Fill urine specimen bottle with sample of 24 hour mixed specimen
- g. Discard balance of urine
- h. Place name and address on chart and attach to specimen for examination
- i. Total intake and output
- j. In diabetes "fractional specimens" may be ordered
 - (1) Specimen is collected as before and labeled and saved for specified hours
- k. Wash and boil equipment

24 Hour Specimen Record

First urine voided on arising should not be saved,

Date: _____

Note time here: BU

A. M.

	Hour	Amount voided	Hour	Kind of fluids taken	Amount
In measuring cup					
In measuring cup					
In measuring cup					
In measuring cup					
In measuring cup					
In measuring cup					

Total voided: _____

Total intake: _____

Name: _____

Address: _____

I. URINALYSIS TESTING TECHNIQUES

1. Purpose

- a. To suggest nursing techniques to be used in following the orders of the attending physician, or standing clinic orders

2. Equipment

- a. Enamel basin with cover
 - (1) Galatest for sugar
 - (2) P.D. & S. Co., Albumin Test Solution
 - (3) Test tube and holder
 - (4) Medicine dropper
 - (5) Green soap

3. Procedure

- a. Use approved home visit procedure, give care to patient, do urinalysis last
 - (1) Sugar testing (Galatest)
 - (a) Deposit on a piece of plain white paper a little of the powder (covering an area about the size of the little finger nail)
 - 1) Use medicine dropper and deposit one drop of urine on the powder. If powder is flooded, repeat the test
 - (b) Results
 - 1) If sugar is present 0.1% or over, the powder will instantly turn grey or black, indicating amount of sugar present. (See chart with test)
 - (2) Albumin Testing (P.D. & S. Co.)
 - (a) Add 3 to 5 drops of test solution to test tube half full of urine
 - (b) Hold against a dark background
 - (c) Results, a cloudy precipitate will develop in the presence of albumin
 - (3) Cleansing equipment
 - (a) Cleanse equipment with green soap and water, rinse with clear water, dry, and return to enamel basin and bag
 - (4) Record results on Family Nursing Record, and Action Report for physician or clinician

J. RABIES - WHAT TO DO IF ONE BELIEVES A DOG TO HAVE RABIES

- 1. First, confine the dog. The clinical symptoms of a dog are your best evidence of the possibility of rabies infection. If the dog is killed early in the infection, it is impossible for the laboratory to demonstrate microscopic evidence of the disease; hence you have lost your only means of diagnosing the infection

a. By regulation the dog must be confined 12 to 14 days, but dogs have been known to have incubation periods up to 30 days. It is advisable to confine the dog for this period

- (1) If the dog in question has been killed before the report came to the physician or health officer, or if the confined dog dies, the head should be removed by a veterinarian or physician using all precautions to avoid contamination of the operator
- (2) This head should be placed in a tin container that is water-tight, for example, a syrup bucket with a tight fitting lid. This small container containing the head should be placed in a larger container (garbage can) that will retain water, and the whole liberally packed in ice
- (3) This outside container should be carefully labeled in order to give proper warning to those who are to handle such a container (containers are good stock equipment for the local health department to keep on hand)
- (4) It must be sent by Railway Express to the nearest laboratory equipped to handle such material, e.g., the State Public Health Laboratory. The following note should be attached to the container:

CAUTION - THIS PACKAGE CONTAINS THE HEAD OF A DOG (OR OTHER ANIMAL) SUSPECTED OF HAVING DIED OF HYDROPHOBIA

- (a) NOTE: The American Railway Express Company will accept animals' heads for shipment under the following conditions:

"The head of the dog or other animal....must be placed in a tin or metal container, which will not permit the leakage of fluids; such container shall then be placed in a second wood or metal container with ice packed around it; such outside container must be so constructed that it will not permit the leakage of the ice water.

"Such shipments tendered on Saturday, which cannot reach their destination early enough for delivery on that day and would, therefore, remain in the express office over Sunday, must be refused, and the shipper requested to pack in ice and hold until Monday, so that they can be delivered without delay at destination."

Prepayment of charges on shipments of this kind is required.

- (5) The laboratory, upon receipt of the head, will make a microscopic examination of the brain tissue. If negri bodies are demonstrated, the laboratory will report this to the health officer or physician submitting the specimen. (If no negri bodies are found on tissue examination and if an individual has been bitten, the laboratory will perform laboratory inoculation to further aid in diagnosis upon request of the health officer). This is good evidence that the dog in question was suffering from rabies at the time he was killed

2. What dogs' heads should be sent to the laboratory?

- a. The head of a dog that has shown definite signs of clinical rabies and which bit an individual
- b. The head of a dog exhibiting clinical evidence of rabies even though it has not bitten an individual, if there is reason to believe that this is the first dog showing some symptoms in that area or if this dog has bitten livestock. This examination is made primarily to ascertain whether rabies has recently appeared in this area
- c. If it is definitely known that rabies is prevalent in the area and if the dog in question has not bitten an individual, it is not necessary to submit the head to the laboratory, but the dog should be killed and the body burned

3. If an individual is bitten by a dog, he should immediately call his physician and follow any procedure the physician prescribes. At the same time, he should call his health officer and relate all possible information relative to the dog; for example, had the dog exhibited unusual characteristics? Had he been overly affectionate? Had he wandered from place to place? Did he have difficulty in eating or drinking? What was the expression in his eyes? Did the lower jaw hang down, apparently out of control? Was he in any way paralyzed?

- a. This information should be given to the health officer and should be transmitted to the laboratory when the head is shipped for examination
- b. When it is indicated to kill the animal, it should never be shot or clubbed in the head. The veterinarian or a physician must prepare the head for shipment

4. Nurse's responsibility

- a. To work in cooperation with the sanitarian on the direction of the health officer as suggested in the control of rabies

- b. The local law enforcement authorities should be advised of a suspected infected animal
- c. The health department is responsible for isolating and chaining the animal
- d. The local law officials are responsible for enforcing isolation of suspected animals if family cooperation has not been obtained upon the request of the health officer

K. *Enterobius vermicularis* (pinworm, seat worm, thread worm)
This worm is sometimes placed in the genus Oxyruis

- 1. The ova of Enterobius are more often on the skin of the perineal regional than in the feces
- 2. Scraping and swabbing this area is an effective method of recovering these eggs
- 3. The State Public Health Laboratory will supply a container with a cellophane swab suitable for collecting such a specimen
 - a. The swab should be used in the morning before defecation or a bath
 - b. After scraping the anal region with the cellophane tip, replace the cellophane-tipped swab in the tube and send to the laboratory
 - (1) The use of this cellophane swab will enable the laboratory to demonstrate the ova of *Enterobius vermicularis* many times more frequently than they are able to do by the examination of stool specimens only

PART VI

FORMS, RECORDS AND REPORTS WITH DIRECTIVES FOR THEIR USE

- A. GENERAL SUGGESTIONS
- B. CODE FOR DAILY REPORT
- C. DAILY REPORT
- D. SCHEDULE FOR THE MONTH (ITINERARY)
- E. INSTRUCTIONS FOR SPECIAL TABULATIONS AND INTERPRETATION OF SUPPLEMENTAL PAGES FOR ALL NURSES' MONTHLY REPORTS INCLUDING SCHOOL ACTIVITIES
- F. SUGGESTIONS TO NURSES FOR WRITING QUARTERLY NARRATIVE REPORTS
- G. VISIT PLAN
- H. INDEX CARD
- I. ACTION REPORT FORMS
 - 1. Action Report
 - 2. Teacher's Referral to Public Health Nurse
 - 3. Referral to Physician
- J. NOTICE TO PARENTS
- K. FAMILY SERVICE FOLDER
- L. FAMILY NURSING VISIT RECORD AND CONTINUATION RECORD
- M. RECORDING SERVICES (SUGGESTED GUIDE)
- N. IMMUNIZATION RECORD
- O. COMMUNICABLE DISEASE FORMS
 - 1. Original Report Card of Communicable Disease No. 16-10392
 - 2. District Communicable Disease Report Card (salmon color)
 - 3. Communicable Disease Report Card No. 16-10360
 - 4. Epidemiological Record (pink form)
 - 5. Warning Placard
- P. PHYSICIANS INITIAL AND PERIODIC REPORT OF TUBERCULOSIS CASES
- Q. MATERNITY FORMS
 - 1. Maternal and Child Health Clinic Slip
 - 2. Maternity Record
 - 3. Clinic Appointment Card

R. MIDWIFE SERVICE CARDS AND FORMS

1. Midwife Record
2. Midwife Notice that She has Been Engaged to Attend a Maternity Patient
3. Statement of Medical Examination
4. Midwife Notice of Delivery to Local Health Department
5. Midwife Call for Assistance Form
6. Midwife Annual Report

S. NOTIFICATION OF BIRTH REGISTRATION

T. CLINIC APPOINTMENT POSTAL CARD

U. WELL CHILD CLINIC RECORD

V. NEW MEXICO ELEMENTARY CUMULATIVE RECORD

W. CRIPPLED CHILDREN'S RECORDS

1. Referral Form CCS 33-R
2. Report of Public Health Nurse CCS-10

X. LABORATORY

1. General Suggestions
2. Bacteriologic and Serologic Examinations
 - a. Wassermann
 - b. Agglutination Tests
 - c. Malaria
 - d. Diphtheria
 - e. Feces
 - f. Gonococcal
 - g. Rabies
 - h. Sputum
 - i. Urine

Y. TEAMWORK - An Editorial Without Words

PART VI - FORMS, RECORDS AND REPORTS WITH DIRECTIVES FOR
THEIR USE

A. GENERAL SUGGESTIONS

1. Closing of records

- a. Transfer of record summary from county to county or from state to state
 - (1) Summary of Family Folder Record, Clinic Record, Index Card, etc., to be placed on duplicate Index Card and transferred through the district health officer with a letter of transmittal or Action Report. Record is closed and placed in closed file
 - (2) Tuberculosis Register Card
 - (a) Make a copy of the original card and transfer with Action Report to local county health department serving area of new residence in this state
 - (b) If patient moves to another state, summarize as above and mail to the Division of Tuberculosis Control which, in turn, will mail interstate notification
 - (3) Communicable disease
 - (a) Travel of communicable disease cases or carriers is covered by interstate quarantine regulations
 - (b) It is suggested that the Director of County Health Administration be contacted to complete arrangements and interstate reciprocal report
 - (4) Venereal disease
 - (a) Patient may request transcript of diagnosis and treatment from
 - 1) Private physician
 - 2) District health officer
 - 3) Intensive Treatment Center
 - (b) Forms provided are
 - 1) Syphilis transcript of treatment from county office
 - 2) Form #SVDH-15, from Intensive Treatment Center
 - (c) It is suggested that the Director of the Division of Venereal Disease Control be contacted when unusual problems arise
 - (5) Records of deceased
 - (a) Close out Family Folder and Index Card. Follow up tuberculosis and other communicable diseases as suggested

- (6) Records are kept five years after closing and destroyed at the end of the fifth year unless otherwise indicated

2. Quarterly reports

- a. Narrative Report (see Suggestions to Nurses for Writing Quarterly Narrative Reports). The Nurse's Monthly Report, exclusive of the Supplemental Report, is the basis for all statistical data of nursing activities
- b. Tabulation of Health Department Services to be used by the district health officer in reporting the summary of monthly health department personnel activities in the Quarterly Report

3. Monthly report

- a. Clerk summarizes Daily Reports at the end of each week on the Monthly Tabulation Form. From this tabulation she completes the Nurse's Monthly Report

B. CODE FOR DAILY REPORT

1. Standard form used (sample not included)

- a. Follow Revised Instructions of Tabulation of Health Department Services

2. Supplemental Code for Daily Report (sample not included)

Name	Address	Community
Doe, John	834 Delgado	Alameda
1-2-49		
1-18-49		
5-6-49		
9-25-49		
11-26-49		

- a. Purpose of Visit Plan Card
 - (1) To assist nurse in planning her case load
 - (2) To plan visits where most needed
 - (3) To save time and travel, plan visits by community, district or zone
 - (4) To promote better utilization of nurse's energy
 - b. Necessary Equipment Needed for Visit Plan File
 - (1) File box, size 3x5
 - (2) 1 set monthly guides (3x5)
 - (3) 2 sets daily number guides (1-31) Size 3x5
 - (4) 1 Visit Plan Card to correspond with every Family Service Folder in active file
 - c. Procedure for Using Visit Plan Card in File
 - (1) Place monthly guides in box
 - (2) Place complete set of dates (1-31) back of first and second month
 - (3) As day's visits are completed move number guide into third month. Cross out date after visit is made
 - (4) Place Visit Plan Card back of month and date visit is to be made
 - d. Procedure for Planning Visits by Card
 - (1) Place on first line, name of family (surname first)
 - (2) Place of residence
 - (3) Date visit is planned. Placed in file back of this date
 - (4) If for any reason, visit is not made as planned note date for a future visit. Move card behind new date in file
 - (5) If nurse made trip to home and found no one there, plan date for future visit. Move card behind new date in file
2. Family Service Folder - Visit Plan (see sample form)
- a. Purpose - Same as visit plan card
 - b. Necessary equipment
 - (1) File box 5x8
 - (2) 1 set monthly guides (5x8)
 - (3) 2 sets number guides (5x8)
 - (4) 5x8 plain card (to which 3x5 index card is attached)
 - c. Procedure
 - (1) Place Family Service Folder back of date visit is planned
 - (2) If Index Card is used, attach to 5x8 card for easy filing
 - (3) When visits are made move number guides into third month

C. DAILY REPORT

1. Sample form

Worker		County	Date
Joy Blank R.N.		Barclay	6/26/49
CODE	NAME	ADDRESS	REMARKS
D-11	Mrs. Antonio Garcia	225 Galisteo	Home delivery - Demonstrated Care of
E-2-5	Baby Garcia	225 Galisteo	mother and infant
40, F-1	First Grade	King School	Demonstrated School inspection for
2, F-14	Mr. P. Martin, Principal		Scarlet Fever Contacts.
	Mrs. Lena Chavez, Teacher		
2E-1, 2E-2-3, 2E-10		Gordon Health Center,	1-3:30 p.m. Child Health Conf. 1:30-3:30
M-2	Dr. M. Segora	Porifirio	Dr. reported Typhoid Case to P.H.N., Gave
			medical Orders
LA-1-4	Mike Martinez	Amador	(Typhoid) Isolated case. Widal, Stool + Urine
			Cultures taken. Instructed mother in
			isolation technique and Care of Sick.

NEW MEXICO STATE DEPARTMENT OF PUBLIC HEALTH

DAILY REPORT

CODE	NAME	ADDRESS	REMARKS
			(Cont'd)
			Placarded house.
5, L-22	Family Contacts	Amador	Quarantined Contacts - Stool + Urine
			Cultures Taken.
	Office		Action Report on typhoid Case to M.D.
2-19	Joseph Jones		Reported Martinez family to Sanitarian
	Hours on duty: 8		
	Total Clinic hours: 2 1/2		
	Total miles traveled: 14		

Narrative

First typhoid case reported in County in five years. Family refused immunization in 1945. Returned from fishing trip 6/10/49. Epidemiological record started.

2. Suggestions for use

a. To assist nurse to

- (1) Plan day's work before leaving office
- (2) In first column, code services rendered for tabulation on Nurse's Monthly Report and for the Quarterly Tabulation of Health Department Services
- (3) Record names of persons and areas served. To save time in coding when the Teacher's Work Sheet is used, Cumulative School Record, Family Record Folder, Index Card, or Clinic Record, or any record for group service, there is no need to list names under F-1 or F-6, but code the actual number of children seen, e.g., F-1-27, F-6-19, the same as you do for immunizations under Code A (see sample sheet)
- (4) At the end of each day's report, record
 - (a) Total hours on duty
 - (b) Total clinic hours including time for pre-clinic session and post-clinic session
 - (c) Total number of miles travelled
 - (d) Under narrative, significant facts for quarterly narrative
- (5) Give daily reports to clerk at the end of each week

D. SCHEDULE FOR THE MONTH (ITINERARY)

1. Sample form

a. Form to be supplied by local health department

SCHEDULE FOR THE MONTH OF September, 1949

NAME: Joy Doe

ADDRESS: Blank County

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
			1 H.V. Algodones	2 H.V. Placitas	3 Immunization Clinic H.D. Office
5 Holiday (Labor Day)	6 H.V. Madrid Child Health Conf.	7 H.D. Office V.D. Clinic	8 School La Mesa H.V.	9 H.D. Office Tbc. Clinic	10
12 School Pinon Blanco H.V.	13 School San Pedro H.V.	14 H.D. Office V.D. Clinic	15 School San Jose H.V.	16 School Placitas H.V.	17 Immunization Clinic H.D. Office
19 Pena Cuata General Clinic	20 School Madrid Child Health Conf.	21 H.D. Office V.D. Clinic	22 School Algodones H.V.	23 H.D. Office Tbc. Clinic	24
26 H.V. Maternity Clinic H.D. Office	27 School San Pedro H.V.	28 H.D. Office V.D. Clinic	29 School La Mesa H.V.	30 Office Monthly Report " Itinerary Visit Plan Box	

DPHN

2. Purpose

- To be used in conjunction with Visit Plan Cards in planning tentative work schedule for each nurse
 - For office and/or supervisor's desk
 - For nurse's notebook
- May be used for planning yearly units of work

INSTRUCTIONS FOR SPECIAL TABULATIONS AND INTERPRETATION
OF SUPPLEMENTAL PAGES FOR ALL NURSES' MONTHLY REPORTS
INCLUDING SCHOOL ACTIVITIES

The additional items appearing on the Supplemental Code are not to be included in the Quarterly Statistical Report. The purpose of these supplemental pages is to give additional information regarding nursing activities and to afford the field nurse an opportunity to tabulate the additional services performed. The reason a code number appears on both reports is to clarify interpretation.

A. COMMUNICABLE DISEASE CONTROL

Immunizations:

- 20. Other Service (specify) -
Only completed plain pertussis vaccine
- 23. Completed mixed vaccine -
Specify product
- 24. Tetanus -
Include only when plain tetanus immunization is completed
- 25. Schick tests read -
Record number read
- 26. Number of cases referred to County Department of Public Health -
This counts cases referred to County DPH by others than members of immediate family

B. VENEREAL DISEASE CONTROL

- 8. Admissions to nursing service -
This applies to venereal disease patients or contacts that a nurse visits either in the field or in the office. A record should be made with entry as to the content of the visit
- 9. Office visits -
This applies to an individual who comes to the office for advice regarding venereal disease. An entry may be made on nursing record of the content of this office visit, or in the case where no nursing record has been opened, an index card may be used for this entry. These should be filed in the master file. This provides for continuity of service. Conferences with physicians may be coded under this item providing they are recorded
- 10. Serology taken by nurse -
Blood taken by nurse for laboratory tests, either clinic or field, are included under this coding
- 11. Patients delinquent and returned for treatments -
A delinquent patient is defined in the Public Health Regulations as one who has failed to report within ten days after date designated by attending physician

12. Number of cases referred to County Department of Public Health -
This counts cases referred to County DPH by others than members of immediate family
- C. TUBERCULOSIS CONTROL
 10. Other service (specify) -
Number of tuberculin tests read. Record only number read
 13. Number of cases referred to County Department of Public Health -
This counts cases referred to County DPH by others than members of immediate family
- D. MATERNITY SERVICE
 22. Visits to subregistrars -
Code each contact as one visit
 23. Antepartal cases admitted to dental service -
Record visits to private dentists when State Department of Public Health personnel have assisted maternity patients in securing dental care
 24. Number of patients referred to County Department of Public Health -
This counts cases referred to County DPH by others than members of immediate family
- E. INFANT AND PRESCHOOL HYGIENE
 21. Number of infants referred to County Department of Public Health -
This counts cases referred to County DPH by others than members of immediate family
 22. Number of preschools referred to the County Department of Public Health -
This counts cases referred to County DPH by others than members of immediate family
- F. SCHOOL HYGIENE
 14. Conferences with school personnel -
Include health conferences with all school personnel
 15. Conferences with parents -
Include conferences with parents regarding school health needs
Do not confuse this item with a nursing visit
 16. Number of first aid treatments given by nurse -
Indicate number of first aid treatments given in accordance with Standing Orders. NOTE: Treatment should be continued only under the order of a physician
 17. Patients transported by nurse -
This includes trips to home, physician and hospital
Refer to School Health Manual, Part IV, No. 9

18. Tabulation of follow-up program for conditions indicating need of correction - (1) through (17)

- a. Referred by teacher
- b. Referred to parent
- c. Conferences, parent-nurse
 - (1) Office
 - (2) Home
 - (3) Telephone
- d. Contacts, nurse-physician
- e. Number under treatment
- f. Number corrected

NOTE: Tabulate data for items 'a' through 'f' under conditions listed. Items (1) through (17) are self-explanatory in accordance with Cumulative School Health Records, with the exception of (8) and (15). Under (8) include rheumatic symptoms; under (15) include nervous symptoms

G. ADULT HYGIENE

- 6. Number of adults referred by nurse -
Include only when record is made

H. MORBIDITY SERVICE

- 13. Assistance with admittance to hospital -
This item was added so that the nurse may indicate service rendered in securing hospitalization for medical, surgical and obstetrical cases

I. CRIPPLED CHILDREN'S SERVICE

- 10. Contacts by nurse with Department of Public Welfare.

Specify type:

- a. Personal
- b. Telephone
- c. Total

It was thought this item would solve the coding problems for much time spent which cannot be included at present. While personal contacts are valuable, much routine information may be obtained and given by telephone. Hence, we ask that the nurse specify type of contact

- 11. Number of patients transferred from other services -
Include a child carried on infant, preschool or school record where a crippling condition has become the principal need

- 12. Office nursing visits -
Field and office visits have been coded under "I-6" - "nursing visits." This will not be changed. In other words, "I-6" will be a total of "I-6" and "I-12". It is considered valuable to know what proportion of nursing visits on this service are office visits. By coding visits only under "I-12" the State Department of Public Welfare will be able to compute the two types of visits

- 13. Conferences with school personnel -
Include conferences with school personnel regarding
crippled children only
- J. GENERAL SANITATION
 - 19. Nurse referrals to sanitarian -
(It is suggested that the nurse familiarize herself
with the scope of the sanitarian's work.)
- K. PROTECTION OF FOOD AND MILK
 - 13. Nurse referrals to sanitarian -
(It is suggested that the nurse familiarize herself
with the scope of the sanitarian's work)
- L. LABORATORY
 - 22. Number of specimens collected by nurse (specify) -
(This does not include serology)
Specify and code "L-22"
- M. MISCELLANEOUS
 - 1. Total non-contact visits -
Include all visits when contact is not completed
 - 2. Total community contacts -
State number of organizational and educational con-
tacts
 - 3. Films shown -
In addition to recording public lectures and talks
under proper subject headings, indicate the number
of films shown under "M-3". For continuity of
service, it is suggested that each county set up a
registry indicating name of film, date shown, to
whom shown and attendance
 - 4. Public lectures and talks -
State all public lectures and talks not covered under
specific subject headings
 - 5. Attendance -
Record number
 - 6. Classes conducted -
State number of classes taught
 - 7. Enrollment -
State total enrollment when course is completed
 - 8. Average attendance -
When course has been completed state average total
attendance
 - 9. Total clinic hours -
Include hours spent in preparation of clinic, con-
ference, and dismantling clinic
 - 10. Total miles travelled per month -
State total on duty mileage including travel in
other cars

F. SUGGESTIONS TO NURSES FOR WRITING QUARTERLY NARRATIVE REPORTS

Several nurses have requested guidance in writing their quarterly narrative reports and, therefore, the following suggestions are submitted for assistance. As in the past, keep your narrative original, concise and interesting.

1. PURPOSE

Picture of the work done for the quarter with copies submitted to the county board of commissioners, the local health council, your county and district health departments and the State Department of Public Health

a. Special projects

b. Items not adequately covered by statistical report

c. Scope of services and their balance

d. Follow-up on case histories recorded from month to month

(1) Always identify individual or family by initials, e.g., Family X (Professional confidence is destroyed when names are used)

e. Human interest stories (See "d (1)")

2. GOOD COMPOSITION

a. Accurate with good factual material

b. Interesting to lay and professional people

c. Correct composition, spelling and punctuation

d. Written in third person

3. OUTLINE

a. Discussion or explanation of outstanding features of the work for the quarter, organization, projects, conferences, etc; or, it may be about one of the divisions of the service if it has had interesting or unusual significance

b. Follow code divisions for interesting stories. "F" can include health education projects also

c. Conclusion and future plans

It is generally agreed that narratives fulfill the purpose for which they are written if they are brief and concise. The nurse may make notes on the bottom of the daily report, in the space provided, as to the interesting facts of the day's work. These can then be compiled at the end of the quarter as an interesting narrative.

Narrative reports should accompany Nurse's Monthly Report at the end of each quarter, i.e., March, June, September and December.

G. VISIT PLAN

1. Sample Card Form

Name	Address	Community
Doe, John W.	834 Delgado, Santa Fe	Alameda
1-3-49	7-25-49	
1-10-49	8-29-49	
1-12-49	10-24-49	
1-24-49	11-21-49	
1-31-49		
2-28-49		
3-28-49		
4-25-49		
5-23-49		
6-27-49		

H. INDEX CARD

1. Sample card

Name (surname first) Doe, Mary			No.		
Birth date June 17, 1916		Sex F	Color White		
Head of family John Doe		(Mother) - Mary			
Addresses					
1. 834 Delgado, Santa Fe					
2. 502 E. Garcia, Santa Fe					
3.					
4.					
Date adm.	Service	Date disch.	Date adm.	Service	Date disch.
4/10/30	C.D.	4/25/30			
10/12/36	C.C.S.	6/17/37			
9/18/46	V.D.	7/20/47			

HEAD & WHEELER CO., CHICAGO, ILL., EXCLUSIVE PUBLISHERS

Index Card NOPHN 51 1940

2. Purpose

a. To set up a permanent master index file

- (1) Active
 - (a) Roster of cases being carried
- (2) Inactive
 - (a) Roster of closed cases

3. Procedure for Use

a.. Individual basis

- (1) A card is made on every individual admitted to service
- (2) Identifying information is recorded in spaces provided, e.g., when a woman marries, a new index card is made out with her new name and with her husband named as head of family. Enter on the top line her new married name, her given name, and her maiden name. It is thus possible to refer to her previous records and those of her family
- (3) The lower half of the record summarizes the services rendered and the period covered
- (4) When a child passes from one age classification to another, as when an infant becomes a pre-school child, the Index Card may show a discharge from the infant health supervision service. The Index Card may show two admissions without a discharge as in the case of a tuberculosis patient who becomes pregnant

b. Family basis

- (1) One card is made out for each family coming under care
- (2) If Family Service Folders are used for all cases, a family Index Card may be used. The family name and the name of the head of the family are recorded on the Index Card and the other identifying information may be omitted

c. Short term individual record

- (1) Used in all services when not more than three visits are made
- (2) A short term case for which no family service folder is used. When the desired result or action is secured in three visits or less, the report may be dated, summarized on each visit and written on the back of the Index Card. Nurse's signature on first visit and initial on others. File in visit plan box back of date for return visit. File in master index file upon completion of service
- (3) Home visit or office visit to a school child may be recorded on Index Card. Summarize important information on action report and send it to the teacher, who may copy pertinent information on cumulative school record. File in visit plan file until ready for closing, then file in inactive file.

- (4) May be used in lieu of
- (a) Family Service Folder in minor communicable disease cases, if family does not have a Family Service Folder
 - 1) Use as Visit Plan Card and file under date of release from quarantine in minor communicable disease
 - 2) File in inactive file when case is closed
 - (b) Family Service Folders for follow-up visit for x-ray recheck, tuberculosis survey
 - 1) Sample form

Name (surname first) <u>Doe John Jr</u>				Film No.	
Birth date <u>4-11-1938</u>		Sex <u>M</u>		Color <u>W</u>	
Head of family <u>John Doe Sr.</u>				Telephone <u>254 W</u>	
Addresses				Project No. <u>285</u>	
1. <u>Rte. Box 249 Clovis</u>					
2.					
3.					
4. School Attended. <u>Garmley</u>			Place Employed _____		
Date adm.	Service	Date disch.	Date adm.	Service	Date disch.
<u>4-16-49</u>	<u>C-4</u>				
<u>4-27-49</u>	<u>C-2, -8</u>				
<u>5-26-49</u>	<u>C-7</u>				
<u>6-30-49</u>	<u>C-8</u>				

HEAD & WHEELER CO., CHICAGO, ILL., EXCLUSIVE PUBLISHERS

Index Card NOPHN 51 1940

- (a. Use as a Visit Plan Card and file under date of next visit
- (b. File in inactive file when case is closed

I. ACTION REPORT FORMS

1. Action Report
 - a. Sample form

New Mexico State Department of Public Health

M. Blank

Joy Blank, R.N.

REPORT FROM: TO:

NAME OF PATIENT: Mary Doe

PARENTS: John Doe Martha Doe

Father

Mother

Householder

ADDRESS: 222 Cerrillos Road Santa Fe Santa Fe

Street

Town

County

(Directions)

DIAGNOSIS: Malnutrition, infected tonsils, impaired heart function. D.B.B., M.D.

RECOMMENDATIONS:

8/1/49 Please investigate Mary's health condition. She is falling below par in her school work and has been out of school 18 days this year because of colds and sore throat. M. Blank, 5th Grade Teacher, Mesa Verde School

8/3/49 Interviewed Mary's parents, discussed Mary's condition. Parents plan to take her to family physician with this report for diagnosis and recommendations before school opens. Joy Blank, R.N.

8/4/49 Physical exam.: malnutrition, infected tonsils, impaired heart function. Recommend: bed rest part of each day until school opens. Cod liver oil, 2 tsp. daily. Gave Rx for medication. Tonsillectomy in Spring. Return for recheck before school opens to see if child should enter school. Give... this report to public health nurse and ask her to call me. Other

Physician

Nurse

Other

8/7/49 Report to teacher

D. B. Blank, M.D.

Action Report
DPHN 4-1-48

Joy Blank, R.N.

DATE:

b. Purpose

This form will replace, when present supply is exhausted, the two forms now in use, Referral to Physician and Teacher's Referral to Nurse. This form is used to denote action taken by physician, nurse, teacher or any individual making a report to another individual or agency

c. Procedure

- (1) The form should be completely filled out by individual sending the report. Diagnosis should be that of a physician only
- (2) Teacher copies pertinent information from report on to Cumulative Record and destroys report
- (3) Nurse copies this report from physician on active Service Record
- (4) Files report in Family Folder

2. TEACHER'S REFERRAL TO PUBLIC HEALTH NURSE

- a. Sample form (to be replaced by Action Report when present supply is exhausted)

TEACHER'S REFERRAL TO PUBLIC HEALTH NURSE	
Date.....	8-2.....1949
Name of Pupil:.....	Mary Doe.....School Agua Fria
Address.....	222 Cerillos Road.....Teacher M. Blank Room No. 5
Reason for referral:	Complains of frequent headaches, squints, rubs eyes. Snellen test R. 20/40 L. 20/70
NURSE'S REPORT TO TEACHER	
Date of report:.....	8-16.....1949
Date note sent to parents:.....	8-9-49
Date of interview with parents:.....	8-16-49
Report of conditions found:	Snellen test, same. Eye lids red and crusty.
Result of interview with parents:	Parents plan to take Mary to family physician. Action Report completed and given to parent for physician.
(Signed).....	Joy Blank.....R.N.
Public Health Nurse	
New Mexico State Department of Public Health—Division of Nursing—100M—April 1947	

(1) Purpose

- (a) Teacher to report to nurse conditions observed as outlined in the New Mexico School Health Manual for Elementary Teachers, under C., pages 5 and 6
- (b) Nurse to report to teacher condition found and action taken

(2) Procedure

- (a) Teacher screens children and refers to nurse those having health problems
- (b) Nurse sends notification to parent asking she come to school to discuss the health problem
 - a) Nurse reports results of the interview and action taken to teacher
- (c) Teacher transfers pertinent information from nurse's report to cumulative record

3. REFERRAL TO PHYSICIAN

- a. Sample form (to be replaced by Action Report when present supply is exhausted)

REFERRAL TO PHYSICIAN	
Date	8 - 3 1949
Dear Doctor <u>Blank</u> :	
I have asked that <u>Mary Doe</u> be brought to you for	
(Pupil's Name)	
advice regarding a health condition. The reason for this referral is <u>You were named</u>	
<u>as family physician. Mary is falling below par in</u>	
<u>her studies and has missed 18 days of school this</u>	
<u>year due to Colds and Sore throat</u>	
(Signed)	<u>Joy Blank R.N.</u>
	Public Health Nurse or Teacher
PHYSICIAN'S REPORT	
Date	8 - 3 1949
Recommendations: <u>Rx for high Vitamin, high Caloric</u>	
<u>diet, medication, exercise and rest Return for</u>	
<u>check-up before entering school.</u>	
(Signed)	<u>A.B. Blank M.D.</u>
New Mexico State Department of Public Health—Division of Nursing—April 1947	

- (1) Purpose
 - (a) A form upon which nurse reports significant facts regarding condition of an individual
 - (b) Nurse sends this to family for physician
 - (c) Physician's recommendation to nurse regarding the individual
- (2) Procedure
 - (a) After inspecting child referred by teacher or interviewing family, nurse fills out form giving reason referral and gives to family to take to physician
 - (b) Physician sends recommendations to the nurse

J. NOTICE TO PARENTS

1. Sample form

NOTICE TO PARENTS	
Date <u>8-2</u> - 19 <u>49</u>	
Dear Parent:	
We would like to have you come to <u>Agua Fria</u> School,	
room number <u>5</u>	on <u>8-16-49</u> to see about the health
(Date)	
of <u>Mary Doe</u>	(Name of Child)
Please bring this note with you when you come to school.	
(Signed)	<u>Joy Black R.N.</u> Public Health Nurse or Teacher
New Mexico State Department of Public Health—Division of Nursing—100M—Aug. 1947	

- a. Purpose
To notify parent that an interview is desired regarding health problems of her child
- b. Procedure
Nurse will fill out blanks on this notice and send to parents with the child

DATE	SIGNIFICANT SOCIO-ECONOMIC AND ENVIRONMENTAL DATA
2-25-49	John - laborer. Employer, Blank Construction Co: @ \$1 ⁰⁰ hr (Mo. income averages \$200.00). John Jr. picks berries, asparagus & does odd jobs. Earns \$200.00 - \$10 ⁰⁰ per week. Have 2 milk goats, truck garden - orchard. Supply needs - selling surplus from the 5 acre tract. Rent. 3 room house & tract \$40.00 per mo. Buying furniture \$10 ⁰⁰ mo owes \$100 ⁰⁰ balance. Industrial Insurance from John's salary \$3 ⁰⁰ mo. Adobe house, screens repaired. No storage for perishables. Cross ventilation. Catholic Creed, active in church & school activities. Family seem happy & work together. Welcomed guidance given by N. Joy Blank, RN.

DATE	AGENCIES INTERESTED
2-25-49	Santa Fe Co: H.D.

SUMMARY OF CASES								
INDIVIDUALS SERVED	DIAGNOSIS	DATE	DIAGNOSIS	DATE	PHYSICIAN	DATE OPENED	DATE CLOSED	NO. OF VISITS
Mary.	Postpartal	2-15-49	Early-Latent	3-30-49	John Blank	2-25-49		
John	Syphilis	3-30-49	Early-Latent	3-30-49	I. T. C.	3-24-49		

a. Purpose

- (1) To provide a form on which pertinent facts can be recorded
- (2) To provide a permanent record of services to the family
- (3) Short term cases. See Index Card directive

b. Procedure

- (1) Face sheet (outside of folder)
 - (a) The identifying data should be entered at the time of the first contact with the family, unless obtained previously through other sources, such as clinic records, school records, social service interviews, etc.
- (2) Case number - if used by agency, clerk types number at upper left corner
- (3) By whom referred - friend, mother, physician, or agency such as Red Cross, Welfare Department
- (4) Race - same as birth certificate "Write 'White' if the father or mother is of Spanish, English or Mexican descent, or of any other white race. If he is Chinese or Japanese, write 'Yellow'. If he is Indian, write 'Red' and, if possible, give the degree of Indian blood, such as $\frac{1}{2}$ Laguna, $\frac{1}{2}$ white, or $\frac{4}{4}$ Navajo, et cetera. If he is Negro or has any Negro blood, write 'Black or Negro!'"
"Tober, Billy, State Registrar, MANUAL OF INSTRUCTIONS FOR SUBREGISTRARS, Revised, December 1, 1948, (Items 8 and 13)"
- (5) Date - Family Service Folder opened
- (6) Religion - specify creed
- (7) Name - at the top of the Family Service Folder, should be that of the head of the family, usually the father. Clerk to type surname
- (8) Date
- (9) Address and directions - should give the mailing address and then specific directions for reaching the house if necessary. Space is provided for change of address. All changes of address should be dated
- (10) Telephone number - nearest neighbor in case of emergency
- (11) House screened - note condition of screens
- (12) Number of rooms
- (13) Number of beds
- (14) Toilet facilities
 - (a) Flush type
 - 1) City sewer
 - 2) Septic tank
 - 3) Cesspool
 - 4) Other
 - (b) Privy
 - 1) Sanitary
 - 2) Unsanitary

- (15) Water supply
 - (a) Well
 - 1) Dug
 - 2) Drilled
 - 3) Driven
 - 4) Depth
 - a) Deep
 - b) Shallow
 - (b) Cistern or other container
 - 1) Covered
 - 2) Uncovered
 - (c) Surface supply
 - 1) Arroyo
 - 2) Ditch
 - 3) Creek, pond or river
 - (d) Municipal supply
- (16) Indexed - to indicate that an individual Index Card has been made. Clerk records date
- (17) Family roster
 - (a) Record
 - 1) First name of husband
 - 2) First and maiden name of wife
 - 3) First name of children
 - 4) List extra-familial members under "other" and indicate status - boarder, roomer, etc.
 - 5) Birth place - obtain name of city, state or country where born
 - 6) Date of birth, month, day and year
 - 7) Check (X) if birth certificate (-) if none
 - 8) Marital status (S) single, (M) married, (W) widowed, (D) divorced, (Sep) separated
- (18) Members of family living elsewhere
 - (a) Record
 - 1) Date
 - 2) Last and first name
 - 3) Relationship to head of family -
(F) father, (M) mother, (B) brother,
(S) sister, (U) uncle, (A) aunt,
(GF) grandfather, (GM) grandmother
 - 4) Year of birth, month, day, year
 - 5) Date of departure from home
 - 6) Present address
- (19) Members of family dead
 - (a) Record
 - 1) Same as of "family living elsewhere" and cause of death

- (20) Inside of Family Service Folder
- (a) Significant socio-economic and environmental data
 - 1) In recording information, enter those facts which are of value and may influence the health of the family, such as
 - a) Occupation of family members who are gainfully employed, changes in occupation, including regularity and character of work, employment health hazards, nature of duties, etc.
 - b) Income - include assets and liabilities and ability to manage
 - c) Sanitation and housing - (in addition give information on face sheet) type of house, rent or own property, problems of ventilation, screening, and food storage
 - d) Religion - influence on health attitudes and practices, superstitions, beliefs and customs
 - e) Family relationships; cooperation, harmony, tensions, strains, emotional problems; reactions to health worker
 - f) Milk supply; vegetable supply - own garden
 - g) Community relationships; church, school, and recreation
 - h) Record subsequent significant changes
 - i) On first entry, worker signs full name on following entries may sign initials
- (21) Agencies interested
- (a) Record
 - 1) Date application was made for assistance
 - 2) Name of agency interested in case
 - 3) Date service was terminated
- (22) Summary of cases
- (a) Record
 - 1) In recording information, write name, physician and/or dentist
 - 2) Diagnosis and date (any change in diagnosis is recorded in extra column) and date opened at the time the patient is admitted
 - 3) Upon closing of case, fill in the items, date closed and total number of nursing visits

- (23) File the following records in the Family Service Folder
- {a} Family Nursing Visit Record
 - {b} Continuation Record
 - {c} Physician's orders or referrals (Copy on nursing record, date care instituted)
 - (d) Epidemiological Record until completed and mailed to the Director of County Health Administration (see special uses)
 - {e} Laboratory reports
 - {f} Carbon copy of sanitary inspection of private premises if one is made
 - (g) Other pertinent information - regarding correspondence, etc.

L. FAMILY NURSING VISIT RECORD AND CONTINUATION RECORD

1. Sample Forms

FAMILY NURSING VISIT RECORD			
Family Name <u>Doe</u>		Father <u>John</u>	Mother <u>Mary</u>
Address <u>Route #1, Santa Fe, New Mexico</u>			
Case No. <u>1</u>			
Date	Name	Service Given and Remarks	Nurse
2/18/49	Jane Blank	Midwife, Report of Delivery, 2/15/49 at 2:00 p.m. wt. 5 lbs. still-born, 38 wks. gestation pt. Mary Doe.	Jane Blank
2/18/49	Mary	10 A.M. H.V. 1 st P.P. visit, T.P.R. 98-80-20, B.P. 112/72. All previous pregnancies full term and normal. No prenatal care except exception of last 3 mo's of 1 st pregnancy. N. discussed values of maternity medical or nursing care. General health of family has been excellent. Husband had generalized body rash week of 2/15/49. No fetal movement noted after this date. Labor 12 hrs., 15 min. History of uncomplicated vertex delivery. Gen. condition appears satisfactory. Taking own sponge bath. N. applied supporting breast binder (standing orders.) Breasts are filling. Fundus firm 13 cm. No apparent perineal abrasions or lacerations. N., D. perineal care, discussed values of perineal cleanliness. Pt. will give own care. Lochia moderate rubra. Elimination regular. Family diet discussed, meets specifications of basic seven. N. advised pt. to restrict liquids except of fruit juices. Family attitude excellent. Infant buried 2/17/49. Next visit (5 th day) 2/20/49.	J.B.
2/20/49	Mary	9 A.M. H.V. 2 nd P.P. visit, T.P.R. 98-72-16, B.P. 110/68. General condition and care good. Breasts soft. Fundus firm 5 cm. Lochia alba moderate. Diet of pt. and family satisfactory. Elimination regular. N. to send visit summary to Dr. J.B. Blank whom patient plans to visit for P.P. examination 2/24/49. 3 rd P.P. visit date 2/24/49.	J.B.
2/24/49	Mary	11 A.M. H.V. 3 rd P.P. visit T.P.R. 98-72-16, B.P. 110/64. Breasts soft, no secretion. Fundus not palpable. Up and about home, rest advised. Lochia alba scant. Elimination regular.	J.B.
2/25/49	J.B. Blank, M.D.	"Action Report," sent.	J.B.
3/30/49	J.B. Blank, M.D.	Tel. report to H.D. P.P. examination of Mary neg. Serology of Mary and John positive. Referred to I.H. Wasserman Pos. Kahn Pos. (64) Mazzini 4.	
4/5/49	State Lab * Mary John	Wasserman Pos. Kahn Pos. (180) Mazzini 4.	

New Mexico State Department of Public Health—Division of Nursing—1947

See use of red lines-----Section VI, M, 2, a, (8), (k), and (1)

CONTINUATION RECORD

Family Name Doe Father John Mother Mary Case No. 1

Date	Name	Service Given and Remarks	Nurse
12/22/49	State Lab. Report		
	Mary	<u>Wasserman</u> Pos. Kahn Pos. (16) Mazzini 1	
	John	<u>Wasserman</u> Pos. Kahn Pos. (12) Mazzini 1	
1950			
		Record of service from 4/5/49 to 12/22/49	
		on back of first Family Nursing Visit Record	
		but not shown in the Manual	

2. Purpose
 - a. To record nursing service given to each member of family
 - b. Physician's written orders or nurse's copy of physician's orders
 - c. To record laboratory, clinic and other reports
3. Procedure
 - a. Family name
 - b. Father, first name or initials
 - c. Mother, first name and maiden name
 - d. Case number (if used) to be assigned by clerk
 - e. Address - space should be left for change
 - f. Date - date of visit and dates of laboratory and other reports received
 - g. Name
 - (1) Given name of each individual receiving service
 - (2) Full name and capacity of all persons contacted in behalf of individuals carried on record (name to be underlined in red)
 - h. Service given, medical orders, laboratory reports, etc. See Section K - Recording Services (suggested guide)

M. RECORDING SERVICES (SUGGESTED GUIDE)

1. Purpose

- a. To show the health picture of the individual in the family group
- b. To provide a record of significant facts
- c. To provide continuity of service

2. Recording of service to individual family members

a. Record

- (1) Notations on home, office or clinic visits are opened on the Family Nursing Visit Record, and, if necessary are carried on the Continuation Record
 - (a) School visits and minor communicable disease cases needing intensive service are so recorded
 - (b) See Index Card directive for H.V. or O.V. when desired action is secured in three visits or less, in this case it may be used in lieu of Family Service Folder
 - 1) Minor communicable diseases if not carried as active case on Family Service Folder may be recorded on Index Card as short time record. (See directive)
- (2) Major communicable diseases require
 - (a) Family Service Folder
 - (b) Epidemiological Record
- (3) The name of the worker, whether it be the health officer, nurse, sanitarian, engineer or attendant, should sign the individual entries the first time with his full name and may use initials on consecutive subsequent entries
- (4) Specific information should be recorded by the worker at the time of the visit
- (5) The narrative may be written
 - (a) In the home, and used to help summarize the teaching points with the family
 - (b) In automobile
- (6) Completing record
 - (a) It is suggested that, if possible, the narrative be written in the home and the record completed during each visit. In this way, all pertinent information is recorded

- (7) To facilitate brevity in recording, the following abbreviations may be used

AP	Antepartal	N	Nurse
Ax	Axillary	NB	Newborn
BP	Blood Pressure	Neg	Negative
BS care	Bedside care	OV	Office visit
CC	Crippled child	Pos	Positive
CD	Communicable disease	PP	Postpartal
CL	Clerk	Pre-sch	Preschool.
D	Demonstration	Pt	Patient
DB	Demonstration bath	R	Rectal
DR	Demonstration returned	San	Sanitarian
		Sana	Sanatorium
		Sch	School
Eng	Engineer	SI	Sanitary
HO	Health Officer		inspector
Hosp	Hospital	R/	Treatment
Ht	Height	T.B.	Tubercle
HV	Home visit		bacillus
Inf	Infant	Tbc	Tuberculosis
IP	Intrapartal	Tbc con-	Tuberculosis
M	Mouth	tact	contact
Mat	Maternity	Tbc sus-	Tuberculosis
Morb	Morbidity	spect	suspect
Wt	Weight	T.p.R.	Temperature, pulse and respiration
		VD	Venereal disease

- (8) For each individual receiving service, record the following data on the Family Nursing Visit Record
- Date of visit, enter on space provided
 - First name of patient, enter on space provided
 - Under "service given and remarks" record, use abbreviations, A.M. or P.M., H.V. (Home visit), O.V. (Office visit)
 - Significant facts regarding history of the individual
 - Nursing care given or demonstrated
 - Pertinent information, e.g.,
 - Present condition of patient
 - Progress of patient
 - Instruction given and response to teaching
 - Reaction of patient and family
 - Physician's orders, recommendations and suggestions for care
 - Family plan for treatment and rehabilitation

- (g) Plan for next visit, date, and future supervision, to provide uninterrupted service
- (h) Report of visit to doctor
- (i) Orders may be written on record and signed by physician or the written order copied on record and filed in folder. Use Action Report for reporting services to physician, other individuals or agencies
- (j) Literature given, specify time and special instructions
- (k) Use of red lines
 - 1) Above and below lines noting case summary
 - 2) At close of year two red lines at end of year's final notations
- (l) Use of red underlines
 - 1) Names
 - a) Physicians
 - b) Personnel of agencies interested or individuals contacted
 - c) Laboratory or institution reporting
 - 2) Reports
 - a) Positive laboratory
 - b) Positive x-ray
 - c) Positive results of any test
 - d) Significant data concerning all visits or findings
- (m) In summarizing records or patient's condition, note, i.e., improved, unimproved, maximum progress achieved, dead

3. Services

a. Communicable and noncommunicable diseases

- (1) Suggestions for coding these
 - (a) Communicable - A
 - (b) Tuberculosis - C
 - (c) Venereal disease - B
 - (d) Morbidity - H
- (2) Significant facts regarding history of illness
 - (a) Previous illness
 - 1) Diagnosis, duration, treatment, complications, attending physician, home or hospitalized
 - (b) Present illness
 - 1) Diagnosis, date of onset and possible source of infection (nature of contact), history of onset and present symptoms

- (c) Present condition
 - 1) Ambulatory, confined to bed, etc.
 - 2) Change in weight
 - 3) Undue fatigue
 - 4) Other important facts concerning his physical, mental, and emotional state
- (3) Medical orders and recommendations
 - (a) Plan for care
 - (b) Activities
 - (c) Exercise
 - (d) Rest
 - (e) Isolation
 - (f) Prophylaxis
 - (g) Diet
 - (h) Treatments
 - (i) Rehabilitation
- (4) Nursing care and supervision
 - (a) Medical orders and reports to physician
 - (b) Positive laboratory findings, x-ray and special tests
 - (c) Hygiene teachings
 - 1) Bedside nursing care given or arranged
 - 2) Sleeping arrangements
 - 3) Isolation technique
 - 4) Mental attitude and emotional problems
 - 5) Nutrition
 - a) Diet prescription
 - b) Usual family food habits, intake of patient
 - c) Interpretation of food prescribed in terms of food available to assure adequate diet
 - d) Appetite
 - (d) Plan for future care and supervision
 - 1) Return demonstration of nursing care by attendant or responsible member of the family
 - 2) Convalescence and rehabilitation
 - 3) Instruction to family and extra-familial contacts
 - 4) Release from isolation and/or quarantine
 - (e) Disposition of case
 - (f) Use abbreviations for nursing care
- b. Maternity - code D
 - (1) Antepartal
 - (a) Significant facts regarding previous pregnancies
 - 1) History of previous pregnancies
 - a) Para
 - b) Gravida
 - c) Abortions, spontaneous or induced
 - Before 20 weeks
 - After 20 weeks

- d) Stillbirths, attributed cause
- e) Premature births, attributed cause
- f) Abnormal deliveries
- g) Other complications, syphilis, gonorrhea, cardiac, toxemia, hemorrhage
- h) Menstrual formula
- 2) History of present pregnancy
 - a) First day of last menstruation
 - b) Expected date of confinement
 - c) Date of first movements, "quickening"
 - d) Date when patient began medical and dental supervision for current pregnancy
- (b) Nursing care and plan for delivery supervision
- (c) Antepartal complications
 - 1) Observation and notation of danger symptoms during pregnancy
 - a) Excessive vomiting
 - b) Persistent nausea
 - c) Cessation of fetal movement
 - d) Sudden loss or gain in weight
 - e) Excessive profuse vaginal discharge
 - f) Bleeding
 - g) Dizziness or disturbed vision
 - h) Headaches
 - i) Epigastric pain
 - j) Dyspnoea
 - k) Edema of face, hands or legs
 - l) Constipation or diarrhea
 - m) Persistent headache
 - n) Urinary disturbances
 - o) Feeling of apprehension
 - p) Premature rupture of membranes
 - 2) Hygiene
 - a) See suggested outline for content of antepartal visit and record content of visit
- (d) Intrapartal
 - 1) Date of delivery
 - 2) Place of delivery
 - 3) Attendant
 - 4) Weeks of gestation
 - 5) Presentation
 - 6) Type of delivery
 - a) Spontaneous
 - b) Operative
 - 7) Hours in labor
 - 8) Lacerations or episiotomy
 - 9) Premature rupture of membranes
 - 10) Complications

- 11) Condition of mother
 - a) Lochia
 - b) Breast and nipples
 - c) Condition and height of fundus
 - d) Diet
 - e) Mental attitude
- (e) Postpartal

If patient has not received antepartal or intrapartal care a brief history as outlined above should be taken

 - 1) See suggested outline for conduct of postpartal visits and record content of visit
 - 2) Action Report may be used for reporting services to physician
- (f) Child health supervision

A sick child is admitted to morbidity service, code H. This record must contain definite information if it is to assist the nurse in observation of all factors which effect a child's progress toward physical and emotional maturity

 - 1) Newborn care
 - a) See suggested outline for conduct of postpartal visits and record content of visit
 - b) Action Report may be used for reporting services to physician
 - 2) Infant, preschool, (code E) school, (code F) crippled children's service (code I)
 - a) Significant facts regarding history
 - (1. Mother's physical condition during pregnancy
 - (2. Attendant at birth
 - (3. Duration of labor
 - (4. Type of delivery
 - (5. Premature, immature or normal
 - (6. Birth weight
 - (7. Birth registration
 - b) Developmental history
 - (1. Breast or artificially fed
 - (a. How long
 - (b. Type of formula used
 - (2. First sat alone
 - (3. First walked
 - (4. First tooth
 - (5. First talked, formed first sentences
 - (6. School progress
 - (7. Emotional characteristics at various age levels

- c) Concise description of child's physical and health condition
 - { 1. General appearance
 - { 2. General physique
 - { 3. Posture including muscular coordination
 - { 4. Skin
 - { 5. Scalp
 - { 6. Eyes
 - { 7. Ears
 - { 8. Nose
 - { 9. Throat
 - { 10. Teeth, dental development to date, needs and care
 - { 11. Umbilicus
 - { 12. Genitalia
 - { 13. Defects and abnormalities
 - d) Hygiene
 - { 1. Sleep and rest, sleeping arrangement
 - { 2. Play, kind
 - { 3. Elimination
 - { 4. Fresh air
 - { 5. Cleanliness
 - { 6. Nutrition
 - { a. Diet, food intake
 - { b. Usual family food habits, interval and regularity
 - { c. Interpretation of food needs in terms of food available to assure adequacy, state likes and dislikes
- e) Family relationships
 - { 1. Security or evidence of unusual dependency within family group
 - { 2. Attitudes of family toward each other
 - { 3. Adjustment of family to environment
- f) Medical orders, recommendations and use of Action Report to physician should be recorded on narrative
- g) Use suggested abbreviations for nursing care
- h) Children born after January 1, 1946, should have immunizations recorded in space provided on back of Notification of Birth Registration. If born previous to January 1, 1946, a form certificate is issued to parents, upon which the date of completed immunizations are recorded

- i) Use Immunization Record for parents to request and authorize immunizations Record on Family Service Folder and file Immunization Record
- j) Use Notice to Parents requesting that parents visit office, in regard to the problems of children. Make notations on Narrative, or Index Card when no permanent school record is kept
- k) Use Action Report for reporting physical conditions or suspected defects of physical or emotional conditions indicating need for medical attention. Record on Family Nursing Visit Record. If no permanent record, record on Index Card
- l) Summarize evidence of family's learning experience in response to visits
- m) Plans for future services. For coding purposes, the case is dismissed and then admitted to the next age classification, e.g., the case is dismissed from the infant service and admitted to the pre-school service, etc., when a child passes from one age group to another. When the child enters school, an Action Report of the case summary should be sent to the teacher who in turn transfers the data to the Cumulative School Record
- n) When the major service rendered is concerned with a crippling condition, a summary of the information on the Family Service Folder should be made available to the school and Welfare Department. A child who is carried under Crippled Children's Service or who is given intensive nursing service for a health problem should be carried on a Family Service Folder and pertinent information reported to the teacher on an Action Report
- o) Specify titles of literature
 - (1. Content used during visit
 - (2. Left with patient for specified purposes

N. IMMUNIZATION RECORD

1. Sample Form

IMMUNIZATION RECORD					
Doe Jane		Sex	4	Birth date	1-25-1949
Address 509. Alto					
John		Mary		School	
(Father's Name)		(Mother's Name)			
Immunization	Date	Preparation	Dose	Given By	Results
Whooping Cough	4-19-49	Lederle	1cc	J. Blank	
	5-17-49	"	2cc		
	6-14-49	"	2cc		
Diphtheria	7-12-49	Parke-Davis	1cc		
	8-19-49		1cc		
Combined Vaccine					

New Mexico State Department of Public Health--Division of Nursing--4-47

Immunization	Date	Preparation	Dose	Given by	Results
Smallpox	9-6-49			J. Blank	Scar
Typhoid					
Tuberculin Tests					
Other					

I hereby request that Jane Doe receive the necessary immunizations.
(Name of Child)

Date 4/19/49 Signed Mary Doe
(Parent or Guardian)

2. Purpose

- a. To be used in schools, conferences, and clinics in securing request signature of parent or guardian for requested immunization
- b. Record data to be transferred to
 - (1) Teacher's classroom work sheet, in order that she may transfer to Cumulative School Board
 - (2) On back of Notification of Birth Registration (those issued since January, 1946)
 - (3) Diphtheria or smallpox form of certificate for children born previous to January, 1946

Note: This card may be sent home and returned clean and neat to the schoolroom, when the teacher sends it home, with the child, in an envelope.

O. COMMUNICABLE DISEASE FORMS

1. Original Report Card of Communicable Disease No. 16-10392

SAMPLE CARD REPORTING AN ISOLATED CASE OF MEASLES.	
County <u>Santa Fe</u>	Date <u>August 1</u> , 19 <u>48</u>
City, township, school district, or precinct <u>Santa Fe</u>	
Disease or suspected disease <u>measles</u>	Date of onset <u>8-1-48</u>
Patient's name <u>John Doe, Jr.</u> , age <u>9</u> , sex <u>Male</u> , race <u>White</u>	
Patient's address <u>810 N. Pennsylvania Avenue</u>	Occupation <u>student</u>
School attended or place of employment <u>Doe School</u>	Married Divorced Single
Name of householder or parent <u>John Doe, Sr.</u>	
Number in household: Adults <u>2</u> , children <u>3</u>	
Probable source of infection or origin of disease <u>unknown</u>	
If smallpox; discrete, confluent, hemorrhagic? <u>---</u>	Number of times
successfully vaccinated and approximate dates <u>---</u>	
If typhoid fever, scarlet fever, diphtheria, or septic sore throat, was patient, or is any member of household, engaged in the production or handling of milk? <u>No</u>	
Name of person reporting case <u>Dr. John Doe</u>	
Address <u>Santa Fe, New Mexico</u>	
<div style="display: flex; justify-content: space-between;"> <div> <p>Div. P. D.—Form A</p> <p>Form approved.</p> <p>Budget Bureau No. 68-R097.</p> </div> <div> <p>U. S. GOVERNMENT PRINTING OFFICE</p> <p>16—10392-1</p> </div> </div>	

(a) Purpose

This card is used in reporting cases or suspected cases of communicable or reportable diseases (except tuberculosis and venereal disease (use specific cards for these) by the attending physician. It is also used for recording a report from teachers, parents, nurses or any individual reporting a suspected disease or condition within six hours after diagnosis or suspicion. (See Section 2, Regulations Governing Reporting Notifiable Diseases and Accidents)

(b) Procedure

- (1) This franked card is used by physician to report a case or a suspected case to the county health department
- (2) It is also used by nurses, teachers, parents or any individual to report suspected cases or conditions (except tuberculosis, venereal disease and cancer) to county health department. The clerk (or nurse in county where there is no clerk) may complete this form, but the individual reporting should sign name and title to form. Underline the words "suspected disease"
- (3) This card is to be filed in county health office or district health office as directed by district health officer

2. DISTRICT COMMUNICABLE DISEASE REPORT CARD (SALMON COLOR)

SAMPLE CARD REPORTING AN ISOLATED CASE OF MEASLES DISTRICT COMMUNICABLE DISEASE REPORT CARD			
County	Santa Fe	Date	August 1 19 48
City, township, school district, or precinct	Santa Fe		
Disease or suspected disease	measles	Date of onset	8/1/48
Patient's name	John Doe, Jr.	age	9, sex Male, race White
Patient's address	810 N. Pennsylvania Avenue, occupation student		
School attended or place of employment	Doe School	XXXXXX XXXXXX XXXXXX	
Name of householder or parent	John Doe, Sr.		
Number in household: Adults	2	children	3
Probable source of infection or origin of disease	unknown		
If smallpox, name type _____; number of times successfully vaccinated and approximate dates. _____			
If typhoid fever, scarlet fever, diphtheria, or septic sore throat, was patient, or is any member of household, engaged in the production or handling of milk? No			
Name of person reporting case	Dr. John Doe		
Address	Santa Fe, New Mexico		

Date report received	8/2/48
Date report forwarded	8/3/48
Was the case investigated?	Yes
Measures taken to prevent the spread of the disease or the occurrence of additional cases:	
Placard?	Yes
Isolation?	Yes
Quarantine?	Yes -(Non-immune contacts)
Disinfection?	Concurrent
Other measures?	Education of the public as to the dangers of exposing children to those exhibiting catarrhal symptoms of any kind.
Signature of Health Officer	Henry Doe, District Health Officer
Address	Santa Fe, New Mexico
Dept. of Public Health—Com. Disease No. 1	

(a) Purpose

To report to county or district health department (within 24 hours) health procedures instituted in compliance with New Mexico Department of Public Health Regulations Governing the Control of Communicable Diseases and Regulations Governing the Reporting of Notifiable Diseases and Accidents. (See Section 7)

(b) Procedure

Upon completion of investigation of the disease or suspected disease, the nurse will fill out this card stating measures taken to prevent the spread of the disease or occurrence of additional cases (This card cannot be mailed in franked envelope)

- (1) Method of correctly filling out card. Answer yes or no to the following questions. Placard, isolation, quarantine, disinfection and other measures unless it does not comply with regulations, then give explanation

Example - Measles

a) Example

Placard - Yes
Isolation - Yes
Quarantine - No, contacts immune
Disinfection - Yes, concurrent
Other measures - educate family and public regarding spread of disease and immunization
(See general measures Section 3, pp.9 & 10, Paragraph 4 and 7 under Regulations Governing Control of Communicable Disease)

b) Example

Where case has recovered and contacts are not immune

Placard - No, case recovered
Isolation - No
Quarantine - Yes, contacts not immune
Disinfection - No
Other measures - Educate family regarding quarantine of nonimmune contacts for 15 days from date of last exposure

(2) Filing of card

This card is completed from the original report card and the home visit and filed in the county or district health office as directed by district health officer

- (3) Regarding crippled children and communicable disease: report any communicable disease in family, home, or child under crippled children supervision to local county welfare department on report form CCS-10 for their information and convenience of transmittal to Carrie Tingley Hospital

3. COMMUNICABLE DISEASE REPORT CARD NO. 16-10360

SAMPLE CARD REPORTING AN ISOLATED CASE OF MEASLES	
COMMUNICABLE DISEASE REPORT CARD	
County <u>Santa Fe</u>	Date <u>August 1</u> , 19 <u>48</u>
City, township, school district, or precinct <u>Santa Fe</u>	
Disease or suspected disease <u>measles</u>	Date of onset <u>8-1-48</u>
Patient's name <u>John Doe, Jr.</u> , age <u>9</u> , sex <u>Male</u> , race <u>White</u>	
Patient's address <u>810 N. Pennsylvania Avenue</u> , occupation <u>student</u>	
School attended or place of employment <u>Doe School</u>	XXXXXX XXXXXX XXXXXX
Name of householder or parent <u>John Doe, Sr.</u>	
Number in household: Adults <u>2</u> , children <u>3</u>	
Probable source of infection or origin of disease <u>unknown</u>	
If smallpox, name type <u>---</u> ; number of times SUCCESSFULLY vaccinated and approximate dates <u>----</u>	
If typhoid fever, scarlet fever, diphtheria, or septic sore throat, was patient, or is any member of household, engaged in the production or handling of milk? <u>no</u>	
Name of person reporting case <u>Dr. John Doe</u>	
Address <u>Santa Fe, New Mexico</u>	

16-10360

Date report received <u>8/2/48</u>
Date report forwarded <u>8/3/48</u>
Was the case investigated? <u>Yes</u>
Measures taken to prevent the spread of the disease or the occurrence of additional cases:
Placard? <u>Yes</u>
Isolation? <u>Yes</u>
Quarantine? <u>Yes - (Non-immune contacts)</u>
Disinfection? <u>Concurrent</u>
Other measures? <u>Education of the public as to the dangers of exposing children to those exhibiting catarrhal symptoms of any kind.</u>
Signature of Health Officer <u>Henry Doe, District Health Officer</u>
Address <u>Santa Fe, New Mexico</u>

FEDERAL SECURITY AGENCY
PUBLIC HEALTH SERVICE

16-10360 U. S. GOVERNMENT PRINTING OFFICE

(a) Purpose

Same as district communicable disease (salmon color) report card and in addition

- (1) To be completed by clerk (by nurse if no clerk in office) from the salmon colored card and mailed in a franked envelope from district health office to Division of County Health Administration, New Mexico State Department of Public Health, Box 711, Santa Fe, N. M.

4. EPIDEMIOLOGICAL RECORD (PINK FORM)

SAMPLE FORM

Patient's Name John Doe, Jr. Disease Typhoid fever Case No. _____
 Address 810 North Pennsylvania Avenue, Santa Fe, New Mexico Physician Dr. Doe

HOUSEHOLD ROSTER AND INFORMATION RELATING TO PRESENT CASE

Age <u>9</u>	Sex <u>Male</u>	Information About Present Case — Dates Onset <u>September 20, 1948</u> First seen by physician <u>September 26, 1948</u> Reported <u>September 28, 1948</u> Isolated <u>9/29/48</u> Quarantined <u>None</u> Hospitalized <u>-----</u> Released <u>November 8, 1948</u> Previously Immunized <u>No</u> Remarks _____	Previous Attack — Year Immunized — Month & Year Antitoxin Given — Date Amount Antitoxin — Units
Color <u>White</u>			
Marital Status <u>S M W D</u>			
Occupation <u>School</u>			
Place of work <u>---</u>			

HOUSEHOLD

No.	Name	Age	Sex	Occupation	Previous Attack — Year	Immunized — Month & Year	Antitoxin Given — Date	Amount Antitoxin — Units
1	Pt. John Doe, Jr.	9	M	School	-	No	-	-
2	John Doe, Sr.	35	M	Auto mechanic		6/47		
3	Mrs. John Doe	34	F	Housewife		6/47		
4	Henry Doe	6	M	School		No		
5	Mary Doe	4	F	Pre-school		No		
6								
7								
8								
9								
10								

POSSIBLE SOURCES OF INFECTION
HUMAN

Name	Address	Case	Contact	Carrier
Mary Doe (Aunt)	16 miles Southeast Santa Fe			X

ENVIRONMENTAL

Source of Supplies	Food away from Home In Past 3 Weeks	Public Gatherings In Past 3 Weeks	Sanitary Surroundings
Water <u>City Supply</u>	<u>Visited Aunt for</u>	<u>None</u>	Poor Fair <u>Good</u>
Milk <u>Pasturized</u>	<u>two days two weeks</u>		Toilet: P F <u>G</u>
Fruit <u>Local grocery</u>	<u>before date of</u>		Water Closet
Vegetables " "	<u>onset.</u>		Water: Safe <u>Yes</u>
Other (Specify)			Questionable
			Unsafe
			Screens: Complete <u>Yes</u>
			Partial
			None
			Insects <u>None</u>

DEPARTMENT OF PUBLIC HEALTH

EPIDEMIOLOGICAL RECORD

DISTRICT NUMBER 1 COUNTY OF Santa Fe
 Date Investigated 9/29/48
 By Mary Jones, P. H. N.

New Mexico State Department of Public Health—Division of Nursing—April 1947

LABORATORY SPECIMENS EXAMINED FOR PATIENT

Date	Specimen	Result	Date	Specimen	Result
9/27/48	Blood (Culture)	Positive	10/30/48	Stool and urine	Negative
			11/7/48	Stool and urine	Negative

LABORATORY SPECIMENS EXAMINED FOR CONTACTS

Name	Address	Date	Specimen	Result	Date	Specimen	Result
John Doe, Sr.	Santa Fe	10/3	Stool & urine	Negative			
Mrs. John Doe	" "	10/3	Stool & urine	Negative			
Henry Doe	" "	10/3	Stool & urine	Negative			
Mary Doe	" "	10/3	Stool & urine	Negative			
Mary Doe (Aunt)	16 miles South-east of Santa Fe	10/4	Stool & urine	Positive			
" " "		10/11	Stool & urine	Positive			

RECORD OF VISITS

Date	Remarks	Worker	Date	Remarks	Worker
9/29	Isolated patient	M.J.	9/30	Visited Aunt - Left specimen containers.	
	Instructed family		10/5	Instructed Aunt - Typhoid carrier agreement signed.	
	Left specimen containers		10/7	Visited Aunt - Left specimen containers.	
	for other members of		10/26	Left specimen containers for patient.	
	family.	M.J.	11/3	Left specimen containers for patient.	

M. J.

ADDITIONAL INFORMATION, INVESTIGATIONS, REMARKS, ETC.

Date	Worker
9/29/48	
The following history was obtained from patient's mother. Patient visited Aunt (Mary Doe) for two days with his mother two weeks before date of onset. Repeated stool and urine specimens from the Aunt showed the presence of typhoid organisms. The Aunt gave a history of having had typhoid fever ten (10) years previously. Instructed aunt, had 3 copies of typhoid fever carrier agreement signed, gave one copy to her, filed one copy in office and sent one copy to the State Health Department, as required by the regulations. M. J.	

(a) Purpose

To report epidemiological investigation and results; of major Communicable diseases, to the Director of County Health Administration, New Mexico State Department of Public Health, Box 711, Santa Fe, N.M.

(b) Procedure

- (1) Upon receipt of original report card on any of the following major communicable diseases - diphtheria, typhoids, smallpox, anthrax, amoebic and bacillary dysentery and any other diseases as requested by Director of County Health Administration. The nurse will open the investigation on this epidemiological record and family nursing visit record
- (2) After terminal disinfection the nurse will complete record giving
 - 1) Date released
 - 2) Report of completed laboratory examinations
 - 3) Report of x-ray findings
 - 4) Other related examinations
- (3) Record summary on family nursing visit record and mail the epidemiological record to Director of County Health Administration

NEW MEXICO STATE DEPARTMENT OF HEALTH

WARNING

Communicable Disease Within

No person, other than the health officer, his agent, or professional attendant, shall enter or leave these premises, nor shall anyone remove, mutilate or deface this placard, without permission from the health officer.

(Signed) _____

Health Officer.

PENALTY FOR VIOLATION-\$5.00 to \$100.00 Fine, or 5 to 90 Days in Jail, or Both.

DEPARTAMENTO DE SANIDAD DEL ESTADO DE NUEVO MEXICO

ADVERTENCIA

ENFERMEDAD CONTAGIOSA

ADENTRO DE ESTA CASA

Ninguna persona, a mas del oficial de la salubridad, su agente, o el atendente profesional entrara o saldra de estas premisas, ni debera ninguna persona remover, mutilar, o destruir este cartel, sin permiso del oficial de salubridad.

(Firmado) _____

Oficial de Salubridad.

PENA POR VIOLACION-De \$5.00 a \$ 100.00 de multa, o de 5 a 90 dias de carcel, o ambos.

(a) Purpose

To placard premises as required by law for diseases listed - Section 3, Page 3 and Section 13, Page 5, State of New Mexico Department of Public Health Regulations Governing the Control of Communicable Diseases

(b) Procedure

The public health nurse may, upon written order from district health officer, post or remove this placard

P. PHYSICIANS INITIAL AND PERIODIC REPORT OF TUBERCULOSIS CASES

1. Sample form

<input checked="" type="checkbox"/> Health District		Physicians Initial and Periodic Report of Tuberculosis Cases To The New Mexico Department of Public Health				<input checked="" type="checkbox"/> Initial Report <input type="checkbox"/> Periodic "	
Date <u>July 14</u>		19 <u>49</u>		Age <u>21</u>	Sex <u>M</u>	Race <u>W</u>	
Patient <u>Doe</u> <u>John</u> <u>Jr.</u> <small>(Last Name) (First) (Middle)</small>		Householder <u>John Doe Sr</u>					
Address <u>Rte. 2 Box 356 Espanola.</u> N. M.							
Is address correct? <input checked="" type="checkbox"/> yes <input type="checkbox"/> no New Address: _____							
DIAGNOSIS				LABORATORY			
Present Stage		Present Clinical Status		Sputum			
<input type="checkbox"/> Minimal		<input checked="" type="checkbox"/> Active or Prob. Active		<input checked="" type="checkbox"/> Pos.		<input type="checkbox"/> Smear	
<input checked="" type="checkbox"/> Mod. Adv.		<input type="checkbox"/> Quiescent or Activity Undetermined		<input type="checkbox"/> Conc.		<input type="checkbox"/> Cult.	
<input type="checkbox"/> Far Adv.		<input type="checkbox"/> Apparently Arrested		<input type="checkbox"/> G. Pig		<input type="checkbox"/> No Sputum	
<input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> Arrested		<input type="checkbox"/> Neg.		<input type="checkbox"/> Not Examined	
_____		<input type="checkbox"/> Apparently Cured		<input type="checkbox"/> Other (Gastric, etc.)		_____	
_____		<input type="checkbox"/> Deferred		_____		_____	
_____		<input type="checkbox"/> Deceased		_____		_____	
		<input type="checkbox"/> Deceased Other Than TBC.		_____		_____	
EPIDEMIOLOGY							
Origin: <input checked="" type="checkbox"/> In State <input type="checkbox"/> Out of State _____ (Specify)				<input type="checkbox"/> Pos. <input type="checkbox"/> Smear			
Pt. is <input type="checkbox"/> Is Not <input checked="" type="checkbox"/> under my supervision.				<input type="checkbox"/> Conc.			
Date of last X-ray <u>July 1. 1949</u>				<input type="checkbox"/> Cult.			
<u>George Blank</u> M.D.				<input type="checkbox"/> Animal			
				<input type="checkbox"/> Neg. <input type="checkbox"/> Not Done			

2. Suggestions for use

- a. INFORMATION IN FULL IS REQUIRED
- b. Enclose card in pre-paid or penalty envelope, and mail to district health officer within forty eight-hours after establishing diagnosis
- c. Report any change of data mentioned on reverse side of this card, on one of these cards, and mail to district health officer. Include any change of residence in or out of state
- d. On the first visit to you, of a patient with tuberculosis, please report it as an initial report regardless of how many other physicians he has previously consulted
- e. All subsequent cards sent in by you on this patient should be checked as a periodic visit
- f. One of these cards is to be sent to the district health officer for each patient with pulmonary tuberculosis that is under your care, regardless of any change in status at least every six months
- g. Under the term "other" in the column "present stage," all other forms of tuberculosis may be listed, such as, tracheobronchial, active primary or childhood type tuberculosis, and non-pulmonary tuberculosis
- h. HEALTH OFFICER MUST BE NOTIFIED AT ONCE, WHEN PATIENT IS NO LONGER UNDER YOUR CARE

Q. MATERNITY FORMS

1. Maternal and Child Health Clinic Slip a. Sample form

1. MATERNAL AND CHILD HEALTH CLINIC SLIP

Date of clinic 7-29-49 Place Santa Fe Court House County Santa Fe

No. of hours spent in examinations 2

No. of patients examined:

Prenatal	Postpartum	Infant	Preschool	School
New <u> </u>	New <u> </u>	New <u>3</u>	New <u>2</u>	New <u> </u>
Return <u> </u>	Return <u> </u>	Return <u>9</u>	Return <u>5</u>	Return <u> </u>

Immunizations:

	Total	Name of Product Used	No. Infants	No. Preschool
Whooping Cough	<u> </u>	<u> </u>	<u> </u>	<u> </u>
Diphtheria	<u>1</u>	<u>Parke Davis</u>	<u> </u>	<u>1</u>
Small Pox	<u> </u>	<u> </u>	<u> </u>	<u> </u>
D.P.T.	<u>7</u>	<u>Cutters</u>	<u>5</u>	<u>2</u>
Other	<u>2</u>	<u>Typhoid</u>	<u> </u>	<u>2</u>

Physicians mileage to and from clinic if out of town None

Name of doctor conducting clinic John Blank, M.D.

Signature of nurse in charge Jane Doe, R.N.

- (1) Purpose
 - (a) To report all local maternal and child health clinics to the State Department of Public Health, Maternal and Child Health Division
- (2) Use of slip
 - (a) One completed slip to be mailed to the Maternal and Child Health Division at the close of each well child or maternity clinic session
 - 1) Private physician's mileage must be indicated as actual mileage or none, otherwise he will not be reimbursed
 - (b) Attach to each slip
 - 1) Signed statement of private physician showing hours spent in examinations
 - 2) Signed statement of hourly clinic nurse showing hours spent in clinic

2. MATERNITY RECORD

a. Sample form

Maternity Record

Name Doe (Married) Jane (Given) Blank (Maiden) John (Husband's) Registration No. 129

Address 834 Delgado St., Santa Fe

Referred by Self, former clinic patient Age 37

Plans to be delivered by Native Midwife, Anne Blank At Home

Date of last menstruation 5-7-48 Expected date of confinement 2-14-49

HISTORY OF PREVIOUS PREGNANCIES

Summary: Gravida VIII Para VII Stillborn 0 Abortions 0 Now Living 0

Date	2-7-31	5-6-33	4-8-35	9-10-38	7-8-41	12-12-44	2-14-46		
Attendant	MD	MD	MD	MD	MD	MD	Local Mid.		
Months of antepartal care	1 Mo.	None	None	None	None	None	None		
Place of delivery	home	home	home	home	home	home	home		
Weeks of gestation	40	40	40	40	40	40	40		
Delivery	Normal	Normal	Normal	Normal	Normal	Normal	Normal		
Anesthesia	None	None	None	None	None	None	None		
Instruments	None	None	None	None	None	None	None		
Repair of laceration	None	None	None	None	None	None	None		
Transfusion	No	No	No	No	No	No	No		
Length of labor	10 hrs	3 hrs	2 hrs	2 1/2 hrs	2 hrs	3 hrs	4 hrs		
Stillborn or alive	alive	alive	alive	alive	alive	alive	alive		
Birth weight	7 lbs	?	?	7 1/4 lbs	7 lbs	8 lbs	8 lbs		
Months breast fed	9	7	8	9	7	8	12		

Remarks: 9-29-48 local M.D. who attended patient during first six pregnancies died. local midwife attended '46 delivery. Present pregnancy is the first time this midwife has referred a patient to the local clinic.

Menstrual History: Formula 12 X 29 X 4 Amount Moderate

HISTORY OF PREVIOUS ILLNESS AND OPERATIONS

Colds: Frequency and duration Seldom, of short duration

Pains in joints or rheumatic fever None

Sore throat None Scarlet fever No

Renal disease None Diabetes No

Syphilis denied Date of Treatments Gonorrhea denied

Operations None

Tuberculosis in family denied

Chest X-rays 1943, Neg.

Health of children good

Health of husband good Blood tested 1944, neg. Treatments

Remarks:

History taken by Mary Blank, R.N. Date 9-29-48

INITIAL PHYSICAL EXAMINATION

Date 10-1-48 T.P.R. 98⁸-100-24 Usual Wt. 115 Present Wt. 113^{3/4} Height 60^{1/2}
 Blood pressure 110/68 Urine: Albumen 3+++ Sugar neg.
 General Physical Condition: obese
 Skin: clear
 Eyes: react to L & A. - no discharge
 Ears: circumferential
 Nose: neg.
 Mouth (teeth and gums): good
 Throat: clear
 Neck (lymphatics, thyroid): no adenopathy
 Heart: no murmur or enlargement
 Lungs: clear
 Breasts: no masses - adequate
 Nipples: erect
 Abdomen: striated - relaxed - gravid
 Height of fundus 14 cm

Extremities: neg.
 Perineum: ad. midline laceration
 Vagina: cystocele & rectocele
 Cervix: clean - closed
 Uterus: neg.
 Adnexa: neg.
 Rectum: neg.
 PELVIC MEASUREMENTS: Interspinous 23 cm. Intercristal 27 cm. External Conjugate 21 cm.
 Height of Symphysis 5 cm. Outlet 11 cm. Diagonal Conjugate N.R.
 PELVIC TYPE: Clinical Impression adequate X-ray Diagnosis

LABORATORY REPORTS

Serology: Date 10-1-48 Report neg. Cervical smear: Date 10-1-48 Report neg.
 Hemoglobin: Date 10-1-48 Result 10.35 gm.
11-22-48 11.00 gm.

SUBSEQUENT ANTEPARTAL CLINIC VISITS

1. Date	10-8-48	11-22-48	12-29-48	1-18-49	1-21-49	1-26-49	2-2-49	2-9-49	2-15-49	2-21-49
2. T.P.R.	97-88-18	98-90-22	97-82-20	98-82-20	97-100-20	97-88-16	98-96-22	97-82-22	94-88-24	96-84-24
3. Weight	145 ^{1/2}	146	147 ^{1/2}	150	151	154 ^{1/2}	154 ^{1/4}	153 ^{1/2}	153 ^{1/2}	156 ^{1/2}
4. Urinalysis	alt++	alt++	alt++	alt++	alt++	alt++	alt++	alt++	alt++	alt++
5. Blood pressure	122/48	122/54	122/88	100/50	120/70	128/80	126/80	134/80	140/88	128/88
6. Bleeding	no	no	no	no	no	no	no	no	no	no
7. Membranes	intact	intact	intact	intact	intact	intact	intact	intact	intact	intact
8. Breast care	T.E.	T.E.	advised	regular	regular	regular	good	good	good	good
9. Care of teeth	advised	advised	regular	regular	regular	regular	good	good	good	good
10. Height of fundus	18 cm	22 cm	23 cm	25.5 cm	25 cm	27 cm	27 cm	29 cm	28 ^{1/2} cm	28 ^{1/2} cm
11. Fetal heart	148 Mid	N.H.	140 Mid	140 Mid	L.L.Q. 140	L.L.Q. 130	R.L.Q. 140	R.L.Q. 140	R.L.Q. 140	R.L.Q. 140
12. Fetal movements	active	active	active	active	+	active	active	active	active	active
13. Position	breech	breech	S.P.	h.S.P.	LOT	LOA	ROP	ROA	ROA	ROA
14. Varicosities	none	none	no	no	no	no	no	no	no	no
15. Elimination	regular	regular	regular	regular	regular	good	good	good	regular	regular
16. Headache	none	none	none	none	none	none	none	none	none	none
17. Vis. Disturb.	none	none	none	none	none	none	none	none	none	none
18. Edema	none	none	none	none	none	none	none	none	none	none
19. Diet	see notes	adeg.	adeg.	adeg.	adeg.	adeg.	good	same	high prot.	same
20. Rest	fair	regular	regular	advised	regular	good	good	adequate	regular	regular
21. Other										
22. Signature	H. Black m.D.	H.B.	H.B.	H.B.	H.B.	H.B.	H.B.	H.B.	H.B.	H.B.

FINAL PHYSICAL EXAMINATION

Date 6-3-49 Weight 140
T.P.R. 96-76-18 Urine Albumen neg
Blood Pressure: 128/80
General Cond. good
Skin: clear
Eyes: react to L. & R.
Ears: no discharge
Nose: clear
Mouth: good
Throat: clear
Neck: no adenopathy
Heart: no murmurs
Lungs: clear
Breasts: lactating
Nipples: neg
Abdomen: neg
Extremities: neg
Perineum: same
Vagina: same
Cervix: clean - closed
Uterus: ant. invaginated
Adnexa: neg
Rectum: neg

ONE MONTH EXAMINATION

MOTHER: Date 4-5-49 T.P.R. 97-80-20 Wt. 130
Urine albumen 2++ Blood pressure 130/90
Breasts: lactating
Perineum: fair support
Vagina: normal
Cervix: clean
Uterus: neg
Adnexa: neg
Lochia: none
Rectum: normal
INFANT: Date 4-5-49 Temp. 99 Wt. 9-8
General Appearance: excellent
Skin: clear
Eyes: normal
Ears: normal
Nose: normal
Throat: normal
Mouth: normal
Neck: normal
Lungs: neg
Heart: normal
Abdomen: normal
Genitalia: normal
Spine: normal
Extremities: normal

LABORATORY REPORTS (Continued)

10-8-48 microscopic urinalysis: few epithelial cells
11-22-48 R.B.C. 3,850,000 Urine essentially negative
1-21-49 Urine microscopic epithelial cells, occ.
white cells.

SUBSEQUENT ANTEPARTAL CLINIC VISITS (Continued)

1. <u>2-28-49</u>					
2. <u>96-80-20</u>					
3. <u>156 1/2</u>					
4. <u>neg</u>					
5. <u>138/90</u>					
6. <u>no</u>					
7. <u>intact</u>					
8. <u>good</u>					
9. <u>good</u>					
10. <u>12.9</u>					
11. <u>LLQ 144</u>					
12. <u>active</u>					
13. <u>LOA</u>					
14. <u>no</u>					
15. <u>good</u>					
16. <u>no</u>					
17. <u>no</u>					
18. <u>see note</u>					
19. <u>fair</u>					
20. <u>adeg.</u>					
21. <u></u>					
22. <u>N.B.</u>					

DELIVERY SUPPLIES

Baby Clothes	<u>1-26-48</u>
Baby Bed	<u>1-26-48</u>
Tray and jars	<u>1-26-48</u>
Laundry bag	<u>1-26-48</u>
Bottles	<u>1-26-48</u>
Nipples	<u>1-26-48</u>
Bed linen	<u>12-29-48</u>
Towels	<u>12-29-48</u>
Wash cloths	<u>12-29-48</u>
2 basins	<u>1-26-48</u>
Enema bag	<u>to borrow</u>
Commode	<u>1-26-48</u>
Toilet paper	<u>1-26-48</u>
Perineal pads	<u>1-26-48</u>
Newspaper and pads	<u>1-26-48</u>
Light bulbs	<u>1-26-48</u>
Cotton	<u>1-26-48</u>
Mineral oil	<u>1-26-48</u>
Chest X-ray	
Pelvic X-ray	
Preparatory h.v.	<u>1-26-48</u> by <u>Mary Black</u>
Helper	<u>Mother</u> <u>R.D.</u>

NOTES

- Date 10-1-48 Pt. has cyst like area on inner aspect of lower gum. Pt. states that she has had a similar growth removed at a previous date. Dental care advised. R. saline irrigations. H. Blank, M.D.
- N. discussed hygiene of pregnancy in accord with "Suggested outline" for content of first antepartal visit, made between 4th & 6th month. Pamphlet, "Foods Needed Daily During Pregnancy and While Breast Feeding the Baby" given to pt. and discussed with her in relation to her own and the family diet. N. loaned pt. copy of "Planning for the Baby". Booklet used as a visual aid during conference. Mary Blank, R.N.
- 10-8-48 Cyst unchanged. Orders: Microscopic urinalysis; high protein, salt free diet; and frequent rest periods. H. B., M.D.
- N. reviewed values of high protein, salt free diet. Pt. states that she has 3 daily rest periods of from 20 to 30 Mi. She does not allow herself to become tired. M.B., R.N.
- 11-22-48 Cyst on lip appears to be same size. Pt's general condition appears to be good. Hemoglobin check requested. H. B., M.D.
- Nursing advice in accord with content of suggested outline for content of antepartal visit, second visit. M.B., R.N.
- 12-29-49 General Condition appears good. H. B., M.D.
- 1-12-49 General Condition Unchanged. H. B., M.D.
- N. reviewed values of rest and stressed value to patient of her eating high protein, salt free diet. N. discussed content of 3rd visit, "Suggested outline for content of antepartal visit. Pt. states that she is eating 3 eggs and 1 quart of milk each day. M.B., R.N.
- 2-9-49 Gen. Cond. same. H. B., M.D.
- Pt. states she is following diet and resting as directed. M.B., R.N.
- 2-15-49 Continue high protein diet. Phenobarbital gr. ss tid. H. B., M.D.
- N. discussed contents of 4th visit at 9th month (see outline). M.B., R.N.
- 2-28-49 Pt. has "pitting edema" to knees. Advised to take 3 ss of Castor Oil. H. B., M.D.
- All plans are completed for delivery. Pt. "Following diet". M.B., R.N.
- 6-3-49 Condition of cysts appears unchanged. Regular dental care urged. M.B., M.D.

DELIVERY SUMMARY

Date of delivery. 3-2-49 Delivered by Jane Blank, mid wife

Delivered at Name Period of gestation 40 weeks

Delivery: Normal. yes Operative. No Mechanism ?

BABY: Sex. female Color. good Weight. 8 lbs 8 oz Length. 20 1/4" Temperature. 96 (R)

Caput. No Molding. Slight Fontanels. ?

Lungs. Heart.

Abdomen. Spine.

Extremities. Genitalia. apparently normal

Reaction. spontaneous cry Eye Prophylaxis. AgNO₃ 1% in both eyes

Resuscitation. none needed Anomalies. none observed

MOTHER: T.P.R. 99⁴-76-20 Blood pressure. 142/94 Blood loss. 200 cc Transfusion. None needed

Lacerations. Slight skin abrasion Repair. No

Anesthesia. None Height of fundus. 12 cm firm

General condition. good

If stillbirth: Death occurred: before labor During labor

Cause of death:

If neonatal death: Age. Cause.

If maternal death: Date. Cause.

Birth registered: Date. 3-5-49 By. Jane Blank, midwife

b. Directive for the use of Maternity Clinic Record

- (1) Name
 - (a) Married, surname
 - (b) Given, first name
 - (c) Maiden surname
 - (d) Husband's first name
- (2) Registration No., patient's number in maternity registry
- (3) Address, mailing address and specific directions to house if indicated
- (4) Referred by, state who referred patient to clinic, e.g., physician, self, welfare, etc.
- (5) Plans to be delivered by, specify name of physician or midwife
- (6) At, specify name of hospital, or at home
- (7) Age, chronological age, obstetrically this is important. If patient is in her late thirties and is pregnant for the first time, the relative importance of the child is increased. In other words, the fact that she may never become pregnant again may influence one's judgment in the interests of the child in a manner which may not be considered in younger women who may have other children.*
- (8) Date of last menstruation, give first date of last menstrual period as exactly as possible from patient's statement. If questionable place (?) after date
- (9) Expected date of confinement, calculate by use of Naegell's rule, by adding seven days to the onset of the last menstruation count backwards three months and add one year. (The date thus determined is correct in 10% of the cases, 50% of the remainder deliver in one week)**
- (10) History of previous pregnancies
 - (a) Summary gravida, place numeral to designate gravida of patient. (The term is used with a numeral to designate a woman by the number of times she has been pregnant regardless of the duration of each pregnancy or the nature of its termination. A woman during a third pregnancy is gravida III whether the results of the two preceding pregnancies were abortions, moles, premature or full term babies, born alive or dead***

*Beck, Alfred C., M.D., Obstetrical Practice, 4th Edition, Baltimore, The Williams and Wilkins Company, 1947, p. 163

**Ibid., 3rd Edition, 1942, p. 158

***Public Health Nursing in Obstetrics, Part I, New York, Maternity Health Association, p. 28

- (b) Para, place numeral to designate onset of proper number of labors woman has had. Para O, a woman who has not been in labor, although she may have had one or more pregnancies that terminated as abortions. Primipara, Para I, a woman who is having her first labor (not abortion) and until the onset of her second such labor or more specifically, Para II regardless of the number of pregnancies she may have had that terminated as abortions. A labor followed by a multiple birth increases the para by only one*
- (c) Stillborn, specify number of pregnancies terminating in stillbirths. (A fetus showing no evidence of life after complete birth - no action of heart, breathing, or movement of voluntary muscle - if the 20th week of gestation has been reached, should be registered as a stillbirth)**
- (d) Abortions, state with numeral the number of abortions. (The termination of a uterine pregnancy prior to 7 lunar months (28 weeks) of gestation, regardless of whether the child was born dead or alive)***
- (e) Now living, state number of children born to this mother who are now alive
- (f) Date, specify date of termination of each pregnancy
- (g) Attendant, classify person officiating at delivery, e.g., nurse-midwife, midwife, doctor, neighbor, etc.
- (h) Months of antepartal care, inquire as to month of pregnancy when patient first reported for medical care and subtract from delivery date. State number of months of care received
- (i) Place of delivery, state whether home or hospital
- (j) Weeks of gestation, forty weeks is full term gestation, and fact may be so stated. If an interrupted pregnancy, state at which week terminated

*Public Health Nursing in Obstetrics, Part I, Maternity Health Association, p. 26

**Physicians' Handbook on Death and Birth Registration, 10th Edition, Washington, D.C., Federal Security Agency, Public Health Service, 1949, p. 23

***Ibid., 1939

- (k) Delivery, state vertex or breech
- {l} Anesthesia, was it used? Yes or no. Type if known
- {m} Instruments, were they used? Yes or no
- {n} Repair of laceration, were stitches taken? Yes or no
- {o} Transfusion, was it given? Yes or no
- {p} Length of labor, state number of hours patient specifies having had contractions
- (q) Stillborn or alive, state termination of pregnancy stillborn (S.B.) or alive
- (r) Birth weight, give pounds infant weighed. If questionable, so indicate
- (s) Months breast fed, specify number of months (4), (12), as stated by the mother
- (t) Remarks, all significant facts not covered in summary pertaining to previous pregnancies of patient should be noted in this section
- (11) Menstrual history
 - (a) Formula, age of onset x usual interval between periods x duration of period in cases of irregularity, e.g., 14x20x28 x 3-5, or 14x28x5
 - (b) Amount, state whether flow is moderate, scant or profuse
- (12) History of previous illness and operations, much that will be helpful in the management of pregnancy and labor can be learned from the patient's history. Since the sequellae of certain illnesses cause grave complications in pregnancy, a knowledge of the previous illnesses and their sequellae should lead to the early recognition and, at times, to the prevention of some of the complications of pregnancy*
 - (a) Cold, record patient's statement of frequency and duration of colds
 - (b) Pains in joints or rheumatic fever, record summary of patient's statement
 - (c) Sore throat, record patient's statement. The frequent occurrence of cardiac lesions complicating these conditions should direct our attention toward the possibility of cardiac disease whenever a patient has had tonsillitis, chorea, or rheumatic fever**
 - (d) Scarlet fever, yes or no, with date if patient has had disease, were there any renal complications?

*Beck, Alfred C., M.D., Obstetrical Practice, 3rd Edition, Baltimore, The Williams and Wilkins Company, 1942, p. 161

**Ibid., 4th Edition, 1949, pp. 163-164

- (e) Renal disease, yes or no, with date. Many women who, in the course of pregnancy, show an elevation of blood pressure with or without albuminuria, often give a history of having had scarlet fever. Such patients, accordingly, require careful supervision*
- (f) Diabetes, yes, with date, or no. By the use of insulin, the risk to the mother has been largely eliminated, but the danger to the child is still considerable**
 - 1) Inheritance, it is believed that diabetes is inherited as a Mendelian recessive trait. The child cannot inherit the disease from one diabetic parent alone but only from two diabetics, a diabetic and a hereditary carrier or two hereditary carriers. The children of all diabetics, however, will be hereditary carriers of the disease. Assuming that 25 per cent of our population must be carriers, the possibility of inherited diabetes is at least 25 per cent, whenever a diabetic mother has a child***
- (g) Syphilis, yes, with date, or no. Date, place and type of treatment. Is there a history of miscarriages, eruption or falling hair? Has she taken medicine for a long time? Has she ever had intravenous injections? Because the evidences of syphilis often are obscured in women, the best way to detect the presence of this complication is by the use of the Wassermann reaction routinely at the first visit of every new pregnancy case.**** See New Mexico Senate Bill No. 248, An Act to Prevent Congenital Syphilis - To Prevent the Occurrence of Congenital Syphilis
- (h) Gonorrhea; Yes, with date, or no. Date and place of treatment. Since 80 to 95 per cent of the men in large cities have gonorrhea at some time in their lives, the transmission of the disease to their wives is not uncommon and its association with pregnancy is noted in from one to five per cent of obstetric cases. The influence of this complication on gestation depends upon whether the patient is infected before, during or after conception

*Beck, Alfred C., M.D., Obstetrical Practice, 3rd Edition, Baltimore, The Williams and Wilkins Company, 1942, p. 163

**Ibid., p. 579

***Ibid., p. 583

****Ibid., 4th Edition, p. 164

*****Ibid., 4th Edition, p. 602

- (i) Operations, state date and specify operation. Has she been pregnant since the operation? Was the uterus involved in the procedure? Did it leave a scar in the uterus or was the uterus fixed to the abdominal wall? Either of these might cause complications in pregnancy or labor. Was a vaginal plastic operation done? If so, the possibility of serious injury to the reconstructed pelvic supports by the passage of the child's head must be considered. Was the cervix amputated? Following amputation of the cervix, premature interruption of pregnancy or difficult labor may occur. Was a Cesarean section done? After this operation, the risk of rupture of the uterus during pregnancy and, more particularly, in the course of labor, should be kept in mind*
- (13) Tuberculosis in family, name party known or suspected of having tuberculosis. Is there a history of loss in weight, night sweats, cough, etc.? In all suspicious cases, an x-ray examination of the chest is indicated. Early recognition of tuberculosis affords both the internist and the obstetrician an opportunity to do much for the patient. Modern methods of therapy instituted at the right time greatly increase the patient's chance of recovery. On the other hand, the condition may be aggravated if the tuberculosis is not discovered until late in pregnancy or after the child is born**
- (14) Chest x-rays, record date and place of all chest x-rays of patient or her family
- (15) Health of children, give name of child, dates and significant illnesses of children in household
- (16) Health of husband, give dates and significant illnesses of husband
- (17) Blood tested, yes, with date, or no. Results, if known
- (18) Treatments, yes with date and place, or no
- (19) Remarks, give any additional explanatory data pertinent to history of previous illness and operations
- (20) History taken by, sign name

*Beck, Alfred C., M.D., Obstetrical Practice, 4th Edition, Baltimore, The Williams and Wilkins Company, 1947, p. 164

**Ibid., p. 163

- (21) Date, write date history is taken
- (22) Initial physical examination, one month postpartal examination, and three month postpartal examination will be made and recorded by the physician. Subsequent antepartal clinic visits may be made and recorded by either the physician or nurse
 - (a) Date, record date of visit
 - (b) T.P.R., record temperature, pulse, and respiration
 - (c) Weight, record weight. An excessive gain in weight may be due to too great an increase in adipose tissue or fluid retention*
 - (d) Urinalysis, routine test for albumen and sugar. Results, when indicated, can be recorded as negative. In case of positive findings, as, e.g., albumen or sugar. Deviations from normal of a significant character should be underscored with a red pencil
 - (e) Blood pressure, check and record. Read and observe recommended procedure for taking blood pressure
 - (f) Bleeding, (this refers to vaginal bleeding) write none or see notes and place explanatory remarks under notes on fourth page of record
 - (g) Membranes, indicate "intact" in event patient gives history of membranes rupturing with "see remarks" and under notes on fourth page explain symptoms and note advice given
 - (h) Breast care, usually advised at beginning of seventh month. Write "advised" previous to this write "too early", (T.E.)
 - (i) Care of the teeth, discuss with patient the care she is giving her teeth. If satisfactory write, "adequate". In event care is inadequate write, "see notes", and state problems and advice given under notes
 - (j) Height of fundus, measure and record (cm.)
 - (k) Fetal heart, record position where heard and rate as, for example, lower right quadrant (L.R.Q. 128)
 - (l) Fetal movements, indicate yes or no and make any necessary remarks on fourth page

*Beck, Alfred C., M.D., Obstetrical Practice, 3rd Edition, Baltimore, The William and Wilkins Company, 1942, p. 161

- (m) Positions, state position of fetus in utero, e.g., R.O.A. (Right Occiput Anterior)
- (n) Varicosities, state none or locate as R. leg and record teaching advice, summary under notes
- (o) Elimination, state "regular" or "see remarks" and under notes state problem and teaching advice
- (p) Headache, state "none" or "see remarks" explanation to be made under notes
- (q) Visual disturbance, same notation as above
- (r) Edema, same notation as above
- (s) Diet, write discussed. It is suggested that, "Foods Needed Daily During Pregnancy and While Breast Feeding the Baby," be used as the individual guide for discussing diet with the maternity patient. Problems disclosed regarding diet should be recorded under notes and used as the basis for subsequent dietary discussion
- (t) Rest, note number of hours, or state "see notes", and write problems and suggestions given, in notes
- (u) Other, any significant problem may be listed and commented on at regular visits
- (23) Delivery supplies
 - (a) The list is for checking the supplies for care of mother and baby. When patient has obtained supplies place date in space opposite. If all of the supplies are not ready leave that space vacant until they are available. Place date in column
- (24) Chest x-ray
 - (a) Record date of chest x-rays made during pregnancy. If negative, indicate other findings under notes
- (25) Pelvis x-ray
 - (a) Record date of pelvic x-ray report results under notes

(26) Suggested form of delivery summary,

(a) It is helpful to work out a system of obtaining a delivery summary from either the local hospital or attending physician. All data under this heading should be accurate.

NAME: _____
(Married) (Given) (Maiden) (Husband's)

ADDRESS: _____

Referred to hospital by: _____

Date of delivery: _____ Delivered by: _____

Delivered at: _____ Period of gestation _____ weeks

Delivery: Normal _____ Operative _____ Mechanism _____

Baby: Sex _____ Color _____ Weight _____ lbs. Length _____ inches Temperature _____

Caput _____ Molding _____ Fontanels _____

Lungs _____ Heart _____

Abdomen _____ Spine _____

Extremities _____ Genitalia _____

Reaction _____ Eye Prophylaxis _____

Resuscitation _____ Anomalies _____

Mother: T.P.R. _____ Blood pressure _____ Blood loss _____ cc. Transfusion _____

Lacerations _____ Repair _____

Anesthesia _____ Height of fundus _____

General condition _____

If stillbirth: Death occurred: Before labor _____ During labor _____

Cause of death _____

If neonatal death: Age _____ Cause _____

If maternal death: Date _____ Cause _____

Birth registered: Date _____ By _____

Signed: _____
(Name of Person Completing Summary)

3. CLINIC APPOINTMENT CARD

a. Sample form

CLINIC APPOINTMENT CARD			
Name: <u>Jane Blank Doe</u>			
Address: <u>834 Delgado St.</u>			
Registration Date: <u>9-29-48</u> Number: <u>129</u>			
Date	Time	Date	Time
<u>10-1-48</u>	<u>10²⁰ A.M.</u>	<u>4-5-49</u>	<u>9⁰⁰ A.M.</u>
<u>11-8-48</u>	<u>10⁰⁰ A.M.</u>	<u>6-3-49</u>	<u>9⁰⁰ A.M.</u>
<u>12-29-48</u>	<u>10³⁰ A.M.</u>		
<u>1-12-49</u>	<u>9⁰⁰ A.M.</u>		
<u>1-21-49</u>	<u>9²⁰ A.M.</u>		
<u>1-26-49</u>	<u>9⁰⁰ A.M.</u>		
<u>2-2-49</u>	<u>9³⁰ A.M.</u>		
<u>2-9-49</u>	<u>10⁰⁰ A.M.</u>		
<u>2-15-49</u>	<u>10²⁰ A.M.</u>		
<u>2-21-49</u>	<u>9⁰⁰ A.M.</u>		
<u>2-28-49</u>	<u>9²⁰ A.M.</u>		
Your appointment is important to you! Help us to help you by keeping it. D.P.H. June '49			

- (1) Purpose
 - (a) To provide a permanent record for maternity patient of her appointments
- (2) Use of card
 - (a) Maternity patient to be given card with appointment at time of original registration
 - (b) Patient requested to bring card with her to each clinic. Next appointment will be noted on card

R. MIDWIFE SERVICE CARDS AND FORMS

1. Midwife Record

a. Sample form

1M-4-47

NEW MEXICO STATE DEPARTMENT OF PUBLIC HEALTH Permit No. _____
NURSING DIVISION
MIDWIFE INSTRUCTION SERVICE

MIDWIFE RECORD

NAME Blank, Mary Sex F Color W Marital status M Age 58
ADDRESS: 1420, Agua Fria Santa Fe First contact with midwife 1940
On 8-3-49 Date

Specific directions to home: _____

Grade in school IV Reads Eng Writes Yes Makes out acceptable birth certificate Yes Has practiced midwifery 20 years

Intelligence: Average _____ Below average _____ Above Average ✓ Community standing Good

PERMITS: First permit issued (date) 1940 Dates of renewals to present (year) '41 '42 '43 '44 '45 '46 '47

Current renewals: Date Dec '48 Date _____ Date _____ Date _____ Date _____

Permit refused: Date _____ Reason _____ Date _____ Reason _____

Date _____ Reason _____ Date _____ Reason _____

Date _____ Reason _____ Date _____ Reason _____

NUMBER OF DELIVERIES MIDWIFE SAYS SHE HAS HAD

	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.
19 <u>48</u>	<u>4</u>	<u>2</u>	<u>3</u>	<u>1</u>	<u>2</u>	<u>0</u>	<u>0</u>	<u>4</u>	<u>2</u>	<u>1</u>	<u>1</u>	<u>0</u>
19												
19												
19												
19												
19												

NUMBER OF BIRTHS REGISTERED ACCORDING TO CLERK'S REPORT

	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.
19 <u>48</u>	<u>4</u>	<u>2</u>	<u>3</u>	<u>1</u>	<u>2</u>	<u>0</u>	<u>0</u>	<u>4</u>	<u>2</u>	<u>1</u>	<u>1</u>	<u>0</u>
19												
19												
19												
19												
19												

SEROLOGY TESTS		VISUAL ACUITY State whether with or without glasses		X-RAY EXAMINATION OF CHEST		PHYSICAL EXAMINATION	
Date	Result	Date		Date	Report	Date	Report
12-20-48	Neg:	12-20-48	20 20 L 40 R 20	12-20-48	Neg:	12-20-48	B.P. 140/90
			20 20 L R				
			20 20 L R				
			20 20 L R				
			20 20 L R				
			20 20 L R				

Stool for typhoid carrier: Date _____ Result _____

PLACE OF MIDWIFE MEETING. Santa Fe County Health Dept.

ATTENDANCE AT MIDWIFE CLASSES

[illegible]

SUPERVISION

[illegible]

Code 0—Satisfactory, 1, 2, 3,—slightly, moderately, marked unsatisfactory.

X—Needs attention.....no information obtained, 00—correction.

P—Present

A—Absent

Name: Blank, Mary Address: 1420, Agua Fria

242

b. Suggestions for its use

- (1) This record is opened by the health department personnel on first contact with a midwife
- (2) Class attendance and contents are to be recorded by the class instructor
- (3) Pertinent notes and recommendations

2. MIDWIFE NOTICE THAT SHE HAS BEEN ENGAGED TO ATTEND
A MATERNITY PATIENT (SPECIFIED AS MDW. NO. 2)

a. Sample form

NEW MEXICO STATE DEPARTMENT OF PUBLIC HEALTH	
I have been engaged to attend:	
Name of patient	<u>Mrs John Doe</u>
Address	<u>509, Alto, Santa Fe</u>
On	<u>Oct: 20th 1949</u>
	<small>Date</small>
	<u>Mary Blank</u>
	<small>Midwife</small>
	<u>1420 Agua Fria</u>
	<small>Address</small>
	<u>Santa Fe</u>
	<small>County</small>
<small>MDW. NO. 2 DPHN 4-1-49</small>	

b. Purpose

Card is sent by the midwife to the local nurse.
This is an excellent source of antepartal
patients to be followed as suggested in Maternity
Section part IV, D 3 of this manual

c. Suggestions

Local Health Department's address should be
placed on mailing side of card before it is
distributed to the midwife

3. STATEMENT OF MEDICAL EXAMINATION

a. Sample form

Date..... <u>8-20-49</u>	
I have examined	and find
<u>Mr John Doe</u> (Name of patient)	
her an apparently normal case, suitable for a midwife delivery.	
Remarks: <u>M^{rs} Doe has an appointment to</u> <u>attend clinic on Sept: 17th at 10 AM.</u>	
<u>John Blank</u> M. D.	
It is not safe for a midwife to accept a patient for delivery who will probably not have a normal delivery.	
NEW MEXICO STATE DEPARTMENT OF PUBLIC HEALTH	

b. Purpose

This card will be mailed to the midwife after the first medical examination of the patient. This report indicates those patients who appear to be suitable for a normal delivery

4. Midwife Notice of Delivery to Local Health Department (Specified as MDW No:1)

a. Sample form

NEW MEXICO STATE DEPARTMENT OF PUBLIC HEALTH		
Name of Mother or Guardian	<u>Mr John Doe</u>	
Address	<u>509, Alto, Santa Fe</u>	
Date of Birth	<u>10-21-45</u> AM. <u>5:45</u> P.M.	Sex <u>Male</u> Wt. <u>6-2</u>
Did you see anything wrong with the baby?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
If so, what?	<u>The baby's right foot is turned out from the leg</u>	
MDW. NO. 1 DPHN 4-1-49	Midwife <u>Mary Blank.</u>	

b. Purpose

- (1) This is a source of postpartal referral to the local nursing service. The case should be followed in accordance with suggestions for postpartal service, Part IV D, 4 of this manual

c. Suggestions

- (1) Local Health Department's address should be placed on mailing side of card before it is distributed to the midwife

a. Sample copy

Patient's name Mr John Doe Midwife making call Mary Blank
Address 509, Alto, Santa Fe
Labor started 10-20-49. 10:PM
Baby born 5-45AM or Baby not born M

_____ Patient bleeding.
 _____ Patient uncontrollable.
 _____ Placenta will not come.
 _____ Membranes ruptured at _____. Labor pains have not started.
 _____ Baby is premature. _____ Weight is _____ *lbs* _____ *ozs*
 _____ Baby is in breech position.
 _____ Baby is in crosswise position.
 _____ The cord has come down first.
 _____ The patient has a tear.
☒ _____ Baby does not seem normal.
 _____ Wants nurse to see the patient.
 _____ Patient is bleeding following delivery.

Used by the midwife to request medical aid, or to inform the local health department that guidance is desired for the care of the mother or infant

6. Midwife Annual Report



a. Sample form

MIDWIFE ANNUAL REPORT	
Name <u>Mary Blank</u>	Address <u>1420 Agua Fria</u>
County <u>Santa Fe</u>	Year <u>1949</u>
Number of patients you delivered <u>20</u>	
Number of deliveries attended with doctors <u>2</u>	
Number of deliveries where doctor had to be called for assistance <u>2</u>	
Reasons for calling doctor:	
1. Baby in breech position	
2. The mother was over 18 hours in labor	
Number of patients delivered by you alone who attended Health Dept. clinics <u>22</u>	
Number of stillborn babies delivered <u>0</u>	
Number of premature babies delivered <u>2</u> (Babies weighing less than $5\frac{1}{2}$ lbs.)	

b. To be completed by the midwife as a summary of her activities for each calendar year

S. Notification of Birth Registration

a. Sample form



STATE OF NEW MEXICO

DEPARTMENT OF PUBLIC HEALTH

DIVISION OF VITAL STATISTICS

Notification of Birth Registration

This certifies that the following Record of Birth is registered and preserved in the office of the State Registrar of Vital Statistics of the State Department of Public Health at Santa Fe, New Mexico.

Name Jane Doe Sex Female

Date of Birth 1-25-49 Place of Birth Santa Fe

Name of Father John Doe

Maiden Name of Mother Mary Blank

James R. Scott
DIRECTOR
State Dept. of Public Health

Bryce Lohr
State Registrar of Vital Statistics

IMPORTANT—READ CAREFULLY

This is a complimentary notification that the birth of your child has been registered in the Division of Vital Statistics of the State Health Department in Santa Fe.

Read it carefully and, if errors are found in the statements on this notification, please make the corrections and return it to the State Registrar of the Division of Vital Statistics, whose name and address appear in the lower right-hand corner on the front of this notification.

This notification is not a birth certificate nor a certified copy of one. The original birth certificate is on permanent file in the State Health Department. If a certified copy of the birth certificate is required, it must be obtained from the Division of Vital Statistics of the State Health Department in Santa Fe, for which a fee of \$1.00 is charged.

THE NEW BABY

Your new baby should be provided with the best possible care. Call your public health nurse at the county health department of your county, usually in the Court House, asking for a home visit.

According to U. S. Children's Bureau standards and New Mexico Department of Health recommendations, immunizations should consist of the following:

1. Immunization against whooping cough in the early months of life, preferably at three months of age.
2. Immunization against diphtheria at 9 months of age.
3. Vaccination against smallpox before the end of the first year.

The State of New Mexico requires every child to be immunized for diphtheria and smallpox. No child is permitted to enter school without proof of immunization.

Have your physician or the county public health nurse complete the following form after your child has been immunized:

Smallpox, Date Given <u>6-9-49</u>	Result <u>Scar</u>
Diphtheria, Date Given <u>7-12-49</u> Whooping cough <u>4-19-49</u>	Amt. of 1st dose <u>1cc (Parke Davis)</u> " 1st " <u>1cc (Lederle)</u>
Diphtheria, Date Given <u>8-9-49</u> Whooping cough <u>5-17-49</u>	Amt. of 2nd dose <u>1cc (Parke Davis)</u> " 2nd " <u>2cc (Lederle)</u>
Diphtheria, Date Given <u>6-14-49</u> Whooping Cough <u>6-14-49</u>	Amt. of booster dose <u>2cc (Lederle)</u> " 3rd " <u>2cc (Lederle)</u>
Signed _____ Physician or Public Health Nurse.	

2. Purpose

- (a) Receipt of legal birth registration which is on file in the office of the State Registrar of Vital Statistics of the State Department of Public Health
- (b) Used as a statement of immunization received by the child
 - (1) Parents should be requested to bring the notification to the immunization clinic. Details regarding dosage, product used and manufacturer should be recorded when each immunization is completed

T. Clinic Appointment Postal Card

a. Sample form

NEW MEXICO DEPARTMENT OF PUBLIC HEALTH

Jane Doe is invited to attend clinic
on October 1, 1948 at El Rito Health Center
(Date) (Place)

The appointment is for 10²⁰ ~~P.M.~~ A.M.
(Time) Please advise the nurse if you cannot
keep this appointment.

(Children should be accompanied by an adult member of their household.)

*Please remember to bring your
specimen.*

(Signed) Mary Blank, R.N.
Public Health Nurse

DPHN 4-1-49

a. Purpose

- (1) To specify date and time for clinic
appointment

b. Use

- (1) Mailed to patients who are due in
clinic and have not received a definite
appointment

U. Well Child Clinic Record

1. Record Sample Form

WELL CHILD CLINIC RECORD

Name	Doe, Ann Marie		Sex	Female	Race	White	Date of Birth	12/16/45
Father	Last	Robert	Mother	First	Ann	Maiden Name	Smith	
			Address and directions (1)			Santa Fe, Old Pecos Road, next to Church		
(2)			(3)					
Family Medical History:			Syphilis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Pertussis <input type="checkbox"/> Internal Aurt-Expired 1946			Cardiac <input type="checkbox"/> Nervous and Mental ?		
Child's History—Gestation			40 wks. Born at	Home	Doctor	Registered	Normal	Birth Wt.
Prenatal Care			No	By	Health Dept. Clinic	How long?	Four months	Infant Health Sup. by
Breast fed to			12	Mo.—Weaned at	12	Mo.—Bottle	D	Mo.
Age: (1) C.L.O.			1	Mo. (2) Orange Juice	1	Mo. (3) 1st Tooth	5	Mo. (4) Walked
								Mo. (5) Talked
								18
Disease History Including Date:			Immunizations and Tests			Date and Results		
Diarrhea 1/47			Frequent Colds			Wh. Cough		
Diphtheria			Pneumonia			Diphtheria		
Measles 3/47			Chorea			Small Pox 10/46 Scar		
Mumps			Rheumatism			Typhoid		
Scarlet Fever			Convulsions			Wasserman		
Whooping Cough			Operations			Mantoux or Patch		
Otitis Media			Others			Other Per dipigen 0.2 cc 8/46 0.3 cc 9/46 0.5 cc 10/46		
Date			4-10-49					
DAILY FOOD INTAKE:—Milk			3 C. D.					
Cereal, White or Whole Grain			Wg. 3 x wk.					
Bread, White or Whole Grain			W. 2-3 sl. D.					
Vegetables Potatoes 1 x D. 9/47			3-4 x wk.					
Orange or Tomato			0.9 1/2 C. D.					
Fruits			2-3 x wk.					
Meat, Fish, or Chicken			1 x D.					
Beans Pinto			1 x D.					
Cheese			1 x wk.					
Eggs			2-3 x wk.					
Butter or Oleo			1 t. d.					
Sweets Pop and Candy 2-4 x wk.								
Water			3-4 C. D.					
Cod Liver Oil Oleum Percomorph 9/47								
SLEEP: Hour to bed and up			8 1/2					
Nap—Hours			1 hr. D.					
Sleeps alone			Yes					
HYGIENE: Brush teeth			2 x D.					
Wash face and hands			Yes					
Dresses and undresses self			Helps					
Elimination Control—Bowels 1 x D. - Castoria 1-2 x mo								
Bladder—Day—Night			2. Yes. N. Yes					
Time out of doors			3-4 hrs. D.					
HABITS and PERSONALITY: Feeds self			Yes					
Over dependent			No					
Shy			No					
Temper			Yes					
Fear			Of dark					
Jealous			No					
Speech			Plain					
Pleasure sucking			No					
Nail biting			No					
Body manipulation			No					
DISCIPLINE: Usual type			Yes					
Child's response			Passive					
Illness since last visit			0					
Date for next conference			10-6-49					

Date	4-10-49					
Age	4 1/2 yrs.					
Height	43"					
Weight	40 lbs.					
Nutrition						
Mental						
Skin						
Nodes						
Head						
Fontanelles						
Eyes						
Ears						
Nose						
Mouth						
Teeth						
Pharynx						
Tonsils						
Neck						
Thorax						
Lungs						
Heart						
Abdomen						
Genitalia						
Anus						
Extremities						
Musculature						
Subcutaneous Tissue						
Posture						
Neurological						
Remarks and Recommendations:						

Narrative Notes: 4-10-49 Suggested substitution of fruits, raisins, ice cream for candy and pop. Value of whole grain bread and cereals discussed. Mother reports negative chest X-rays on all adults in family 6 mos. after death of aunt. Oral hygiene discussed and demonstrated - use of laxatives, tamper tantrums and fears discussed. (Reference: Spock THE POKETBOOK OF BABY AND CHILD CARE) K.M.

a. Purpose

To record significant data of Well Child Medical and Nursing Conference

b. Suggestions for recording on Well Child Clinic Record

- (1) Name, family name first, then given name, indicate whether male, female, White, Colored, or Other
- (2) Date of birth, state month, day and year
- (3) Father's name, family and given name
- (4) Mother's maiden name, family and given name
- (5) Address and directions, give mailing address, directions for finding home. Check on subsequent visits whether or not family still has same address
- (6) Family history, family to include grandparents, aunts, uncles, parents and siblings. Check positive findings, place zero in negative findings, question mark if not known. Positive findings may be elaborated in narrative notes, i.e., maternal grandmother - diabetes; uncle - tbc., no contact. Non-familial exposure to tuberculosis, etc., should be recorded in nurse's notes
- (7) Birth history, duration of pregnancy in weeks. Full term gestation is 40 weeks. Check whether birth occurred in home or hospital. Check if delivery was normal; complications of pregnancy such as toxemia, eclampsia, kidney disease, heart disease (state if decompensation occurred), lues, gonorrhea
- (8) Birth weight, state pounds and ounces, 7 - 2
- (9) Infant developmental record
 - (a) Feeding history, breast fed to, indicate duration of breast feeding in months, unless otherwise stated it will be assumed it started at birth
 - (b) Weaned at, state month completely weaned, state month weaned from breast, state month weaned from bottle
 - (c) Type supplementary feeding, state whether whole milk, W.M., or evaporated milk, E.M., amount for 24 hours in ounces, water (H₂O) for 24 hours in ounces, sugar, whether cane, C.S., Karo, K, or dextro maltose, D.M., in tablespoonfuls T.No. of ounces to bottle and No. of bottles and hours fed, i.e., E.M. 12 oz., H₂O 20 oz., C.S. 3 T.; 5x6½ oz. - 6-10-2-6-10

- (d) Cod liver oil, insert amount, age at which started, i.e., 2 t., 1 mo.
- (e) Orange or tomato juice, age and amount started, i.e., 1 mo., 2 oz.
- (10) Development history
Insert age at which phase of development occurs in months, blanks left and filled in as progress is made
- (11) Disease history, specify month and year disease occurred. Blanks to be filled in later if a disease occurs
 - (a) Specific prophylaxis and tests, give dates at which whooping cough, diphtheria, smallpox, or typhoid vaccine were administered. Note results of smallpox, Wassermann, Mantoux or Patch. "Other" may include peridipigen, tetanus, etc.

To assist the staff the three sources of material which are available are given as references to help develop the visit content. The pages are indicated after each subject heading: Spock (S), Infant Care (I.C.), Your Child from One to Six (Y.C.)

It is hoped that this section of the record will prove helpful in development of the conference visit. Narrative notes can be used to develop nature of problem and explain teaching content

- (12) Daily food intake
 - (a) The foods are listed so that a picture of the average daily intake can be secured. The most desirable approach is to question the parent regarding the usual foods included in breakfast, dinner and supper. Then, more direct questions can be asked regarding the foods not mentioned, always phrasing the question so the answer is not indicated

The progress of securing a daily food intake should be considered a teaching process. If the interview is carried on in a conversational manner the parent easily discusses the food groups which are a problem as he or she recounts the food eaten. This gives some indication of the parent's standard of what an adequate diet is as well as showing the problem which he or she recognizes. Thus the nurse's instructions regarding diet are often given during this initial interview with the exception of the introduction of new foods into the infant's schedule. This

is done by the physician. The nurse will probably select suitable educational material and discuss it with the parent. This is then attached to the record, so the physician will know what instructions the nurse has given, with the comment that the physician may want to add some information

On the return visit it is especially important to discuss the foods on which the intake was inadequate on the previous visit. Also, the present intake of the essential protective foods should be rechecked

1) The following code is suggested

Milk: cups, C (the formula may be recorded in this space or under Remarks and Recommendations), milk or evaporated milk - oz., water - oz., sugar - tablespoons or teaspoons, M or EM - oz., H₂O - oz., S-T or t

Cereal: white or whole grain, white, number of servings a week, W - W, whole grain, number of servings a week, WG-W

Bread: white or whole grain, slices white - slw, slices whole grain - sl wg

Vegetables: servings green weekly, servings yellow weekly, servings other weekly, gw, yw, ow

Orange or tomato: orange juice - oz., tomato juice - oz., OJ-oz., TJ-oz., servings orange daily or week, D or W, servings tomato daily or week, D or W

Fruits: servings day or week, D or W

Meat, fish or chicken: servings day or week, D or W

Beans: (refer to dried beans or peas) servings day or week, D or W

Cheese: servings day or week, D or W

Eggs: servings day or week, D or W

Butter or oleo: teaspoons or tablespoons, t or T

Sweets: (include candy, cake, pie, cookies) servings daily or week, D or W

Water: cups daily, CD

Cod liver oil: (or Oleum Percomorph - number teaspoons daily, t (OP - gtts)

- (13) Sleep: indicate time to bed and time up, i.e., 8:00 P.M. - 7:30 A.M., (S) 97-99, 253-257, (I.C.) 50-53, 66, (Y.C.) 13, 49-53
 Nap- hours: indicate number of hours, (S) 211-212, (Y.C.) 49
 Sleeps alone: indicate Yes or No, (S) 99-100
- (14) Hygiene: brush teeth, indicate Yes or No and content of teaching in narrative, (S) 156-163, (I.C.) 97-122, (Y.C.) 110
 Washing face and hands: (Y.C.) 55
 Dresses and undresses self: (Y.C.) 31-33, 56-58
 Elimination control - bowels: state usual number of movements daily, and usual consistency if abnormal, if constipated state method of control, (S) 116-126, (I.C.) 53-67, (Y.C.) 45-48, 133
 Bladder- day, night: indicate if usually controlled, D., Yes or No, N, Yes or No, (S) 196-199, (I.C.) 54-55
 Time out of doors: indicate number of hours, (S) 95-96, (I.C.) 35-37, (Y.C.) 75-88
- (15) Habits and personality: feeds self, indicate Yes or No, explanatory notes in narrative, (S) 212-222, (Y.C.) 39-44
 Over dependent: state problem, (S) 201-204, (Y.C.) 55-85
 Shy: state problem, (S) 201-204, (Y.C.) 55-85
 Temper: state problem, (S) 262-263, (Y.C.) 63-66
 Fear: state problem, (S) 278-281, 291-295, (Y.C.) 60-63
 Jealous: state problem, (S) 268-276, (Y.C.) 67-68
 Speech: state problem, (S) 281, (Y.C.) 93-95
 Pleasure sucking: state problem, (S) 135-143, (I.C.) 55, (Y.C.) 88-90
 Nail biting: state problem, (S) 283, (Y.C.) 91-92
 Body manipulation: state problem, (S) 295-306, 312, (I.C.) 55, (Y.C.) 96-99
- (16) Discipline: usual type, state usual methods, (S) 260-268, (Y.C.) 72-73, child's response, state usual reaction
- (17) Illness since last visit: state nature of illness
- (18) Date for next conference: be certain each patient has an appointment.
- Suggested visit spacing is -
- | | |
|-----------------------|--|
| Infants under 1 year | - once a month if possible |
| Children 1 to 2 years | - every 2 months |
| Children 2 to 4 years | - every 3 to 4 months |
| children 4 to 6 years | - every 6 months to a year |
| children over 6 years | - not more than annually unless special need |

V. NEW MEXICO ELEMENTARY CUMULATIVE RECORD
(SAMPLE FORM NOT SHOWN)

1. This record has been approved, and adopted for use in New Mexico schools by the New Mexico State Department of Education
2. The local superintendent of schools is responsible for purchasing and implementing the use of this record

W. CRIPPLED CHILDREN'S RECORDS

1. Referral form CCS 33-R

a. Sample form

CCS 33R

NEW MEXICO DEPARTMENT OF PUBLIC WELFARE REFERRAL FOR CRIPPLED CHILDREN'S SERVICE

Please use this form in submitting the names of crippled children who are in need of care. Fill out the form completely and mail it to the county unit of the DEPARTMENT OF PUBLIC WELFARE in which the child lives.

Date Aug. 1, 1949

Name of Crippled Child Mary Lee Street 510 Agua Fria Town Santa Fe County SA

Birth Date Aug. 9, 1946 Race W Sex: F

Parents: Father John Mother Jane Guardian _____

Education: Name of School _____ Grade _____

Private Physician: John Blank, M.D. Address Santa Fe

Chief Complaint (Date and mode of onset, probable cause, course, treatment):
Mother states child has had acute
pain in right leg on weight
bearing past two weeks. Apparent
limited motion.

Family's attitude toward treatment: Anxious for care
under CC S.

Has child ever received examination or treatment through Shriners? No

Date _____ Place _____

DISEASES EXPERIENCED	IMMUNIZATION AND TESTS	DEFECTS FOUND IN
Date	Date Result	HEALTH INVENTORY
Typhoid <u>No</u>	Typhoid <u>7-9-18-25, 1949</u> Date: <u>June 3, 1948</u>	
Measles <u>11-9-47</u>	Smallpox <u>8-1-47</u> Scar <u>Flabby</u>	
Whooping Cough <u>No</u>	Diphtheria <u>2-9-47 3-9-47</u> <u>muscle tone</u>	
Diphtheria <u>No</u>	Schick _____	
Otitis Media <u>No</u>	Dick _____	
Rheumatic Fever <u>No</u>	Mantoux _____	
Pneumonia <u>No</u>	Wassermann _____	
Tonsilitis <u>No</u>	Other <u>Whooping Cough - 11-9-46</u>	
Mumps <u>No</u>	Person referring child <u>Mary Blank</u>	
Scarlet Fever <u>No</u>		
Chicken -pox <u>2-9-48</u>	Title and address <u>Public Health Nurse</u>	

(Use other side for additional data.) Santa Fe Co.

Please request
immediate
examination.

b. Suggestions for use

- (1) This form should be completely filled out and submitted to the county unit of the Department of Public Welfare in which the child lives, to be cleared and registered for service
- (2) Under "Chief Complaint" it is not necessary to use orthopedic, plastic or eye terminology. A simple, intelligent description of the condition is sufficient
- (3) Under "Person Referring Child" should appear the name of the district health officer, physician or public health nurse

22. REPORT OF PUBLIC HEALTH NURSE CCS-10

a. Sample Form

CCS 10

NEW MEXICO DEPARTMENT OF PUBLIC WELFARE

CRIPPLED CHILDREN'S SERVICES

REPORT OF PUBLIC HEALTH NURSE

Jane Doe Name of Crippled Child Date of Visit *Aug. 1, 1949*

Parents: Father *Peter* Mother *Mary* Guardian _____

Address: *45 San Francisco* *Santa Fe* *Santa Fe*
Street Town County

Content of Visit: *Inspected Child on July 29, 1949.*
Brace and shoes are in need of repair.
Please arrange for examination at the
Carrie Tingley Hospital Clinic.

Name: *Mary Blank* County Health Dept. *Santa Fe*

b. Suggestions for use

- (1) At the descretion of the nurse this report is to be submitted to the county director of the local unit of the Department of Public Welfare, when it is found that a patient's condition, apparatus, home situation, etc., require attention or adjustment
- (2) Report only those conditions which will need action on the part of the person responsible for such in the Department of Public Welfare, or information that would be of value from a social standpoint

When the present supply of this form is exhausted, Action Report (DPHN 4/1/48) will be used.

X. LABORATORY

1. General suggestions

- All containers sent out by the laboratory are state property and must be used only to submit specimens to the State Laboratory
- When a bacteriologic container has an inner tin container, place form around inner tin container, not around bottle or tube
- Wrap all slides in paper before putting form around them
- Fill out all records completely. Use typewriter or hard pencil in filling out records. On multiple forms, be sure carbon copies are legible. The report is returned on one of the carbon copy forms
- For suggested method of recording laboratory reports, see General Suggestions for Use of Records, Part VI, k., 2., (7), (1)
- Important Note: A report from the laboratory of "No Growth" simply indicates that there was no bacterial growth on the culture media inoculated from that particular specimen. Another specimen should be sent to the laboratory in place of the one reported as having no growth. "No Growth" report should not be considered as negative
- See suggested instructions for nursing techniques of collecting specific specimens

2. Bacteriologic and serologic examinations

- Wasserman (Kolmer Complement Fixation), Standard Kahn, and Mazzini Slide test for syphilis

(1) Sample form

(a) Three copies accompany specimen to laboratory, and report is returned on one of carbon copy forms

("Serologic Reactions and Report Form")

COMPLETE ALL FORMS CAREFULLY AND LEGIBLY		SEROLOGIC REACTIONS AND REPORT	
STATE PUBLIC HEALTH LABORATORY UNIVERSITY OF NEW MEXICO Serologic tests for Syphilis (Kolmer Complement Fixation, Standard Kahn and Mazzini Slide Test)		ALBUQUERQUE, NEW MEXICO Report on serologic reactions used as an aid in the diagnosis of Syphilis. Qualitative report based on Wassermann (Kolmer Complement Fixation), Standard Kahn, and Mazzini Slide test.	
Patient's Name <u>Mary Doe</u> Address <u>Albuquerque 305 Quivira</u>		QUALITATIVE REPORT:	
Age <u>30</u> Sex <u>F</u> Occupation <u>Housewife</u> Anglo <input checked="" type="checkbox"/> Sp. Amer. <input type="checkbox"/> Black <input type="checkbox"/> Ind. <input type="checkbox"/>		NEGATIVE <input type="checkbox"/> POSITIVE <input type="checkbox"/> DOUBTFUL <input type="checkbox"/> Specimen Unsatisfactory <input type="checkbox"/> Insufficient <input type="checkbox"/> Hemolyzed <input type="checkbox"/>	
Purpose of test: Aid to diagnosis <input type="checkbox"/> Check on treatment <input checked="" type="checkbox"/> Prenatal <input type="checkbox"/> Routine <input type="checkbox"/>		If report is Positive or Doubtful, please repeat and mark specimen 'Repeat'	
Stage of Syphilis suspected: Primary <input checked="" type="checkbox"/> Secondary <input type="checkbox"/> Early Latent <input type="checkbox"/> Late Latent <input type="checkbox"/> Late <input type="checkbox"/>		Wassermann test (Kolmer Complement Fixation)	
Congenital <input type="checkbox"/> Acquired <input checked="" type="checkbox"/> Probable date of infection <u>January 1948</u>		Blood serum: .2 _____ .1 _____ .05 _____ .025 _____ .005 _____	
Has this patient had treatment? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Date of last treatment <u>June 1948</u>		Interpretation of results on Wassermann test: Negative <input type="checkbox"/> Positive <input type="checkbox"/> Doubtful <input type="checkbox"/>	
Date Received _____ Lab. No. _____		Spinal Fluid .5 _____ .25 _____ .125 _____ .0625 _____ .0312 _____	
<div style="border: 1px solid black; padding: 5px;">Report to: <u>John Smith, M. D.</u> <u>1550 S. Harvard</u> <u>Albuquerque, New Mexico</u></div>		Colloidal Mastic _____ Cell Count _____	
		Protein Pandey's _____ Ross Jones _____ Normal Sugar _____	
		Kahn Standard _____	
		Antigen Suspension: .05 _____ .025 _____ .0125 _____	
		Interpretation of results on Kahn test: Negative <input type="checkbox"/> Positive <input type="checkbox"/> Doubtful <input type="checkbox"/>	
Kahn Verification: 37% .05 _____ .025 _____ .0125 _____		Kahn Verification: _____	
1% .05 _____ .025 _____ .0125 _____		Kahn Quantitative: _____ Units _____	
Previously reported to State Dept. of Health; Case No. _____		Mazzini _____ Date of Report _____ M. Greenfield Laboratory Director.	
No charge has been made for serologic examination.			

(2) Procedure

(a) Fill out forms completely

- 1) Be sure to put return address of physician or health department on form, also put return address on outside of container
- 2) If a blood specimen is to be tested for a premarital certificate, mark the form "Premarital" and give the state in which the marriage is to take place
- 3) If the blood specimen is for a prenatal test, check the form "Prenatal Test". See Senate Bill #248
- 4) If the serologic specimen is on a treated case, mark the form "T"
- 5) If the serologic specimen is a former Intensive Treatment Center patient, mark the form "K"
- 6) If the serologic specimen is a repeat on a routine test, mark the form "R"

b. Agglutination Tests

- (1) Blood for typhoids (Widal, blood clot culture), undulant fever (brucellosis), tularemia. Specify tularemia examination by crossing out typhoid and insert tularemia
- (2) Sample form

BLOOD FOR TYPHOID OR UNDULANT FEVER STATE PUBLIC HEALTH LABORATORY UNIVERSITY OF NEW MEXICO, ALBUQUERQUE			
Please fill out this side of blank in full and return to laboratory with blood.			
Patient's name	John Doe	Address	305 Quivira
Physician's name	John Smith, M. D.	Address	
Patient's age	40	Sex	M
		This is the 1st, 2nd, 3d specimen	
How long since disease commenced?	1 week	Date of taking specimen	June 30
Clinical diagnosis	Typhoid		
When, if ever before, has patient had typhoid fever?	Never		
When, if ever, has patient been vaccinated against typhoid fever?	Never		
To	John Smith, M. D.		
	1550 S. Harvard		
Address	Albuquerque, N. Mex.		

c. Blood for Malaria Examination

- (1) Sample form

BLOOD FOR MALARIA EXAMINATION STATE PUBLIC HEALTH LABORATORY UNIVERSITY OF NEW MEXICO, ALBUQUERQUE			
Please fill out this blank in full, and return to laboratory with specimen			
BLOOD FOR MALARIA EXAMINATION			
Patient's name	John Doe	Address	305 Quivira Albuquerque
Physician's name	John Smith, M. D.	Address	1550 S. Harvard
This is the 1st, 2d, 3d	1st	specimen.	
Has quinine been administered before preparation of smears?	No		
Has patient been in a malaria country?	No		
The preparations were made—During a chill?	After a chill?		Yes
long? 8 hrs	Clinical diagnosis	Date	June 10, 1949
	Malaria		
to	John Smith, M. D.		
Address	1550 S. Harvard Albuquerque, N. Mex.		

d. Diphtheria Kits or Dry Swab Container
(1) Sample form

DIPHTHERIA	
STATE PUBLIC HEALTH LABORATORY	
UNIVERSITY OF NEW MEXICO, ALBUQUERQUE	
Please fill out this side of card and send to laboratory with specimen	
Patient's name	John Doe
Address	305 Quivira
Age	20
Sex	M
Occupation	Student
Anglo	<input checked="" type="checkbox"/>
Sp. Amer.	<input type="checkbox"/>
Black	<input type="checkbox"/>
Purpose of Test:	Aid to Diagnosis <input checked="" type="checkbox"/> Food Handler <input type="checkbox"/> Release from Convalescence <input type="checkbox"/> Release of Contact <input type="checkbox"/>
It is the 1st, 2nd, 3rd	1st culture.
Has an antiseptic been used within twelve hours in nose or throat?	No
Clinical diagnosis	Diphtheria
Date of taking culture	June 12, 1949
Source: Throat	<input checked="" type="checkbox"/>
Nose	<input checked="" type="checkbox"/>
Please use swabs as labeled "Throat," "Nose"	Report to John Smith, M. D.
	Address 1550 S. Harvard
	Albuquerque, N. Mex.

- (2) Virulence tests may be requested for release of
- (a) A case - whenever a case has been in isolation four weeks or more with persistent diphtheria like bacilli
 - (b) Persistent carriers, whether contact or case, shall be reported to the State Director of Department of Public Health

e. Feces Examination

- (1) Specimen for typhoids, dysenteries, etc.

FECES EXAMINATION	
STATE PUBLIC HEALTH LABORATORY	
UNIVERSITY OF NEW MEXICO, ALBUQUERQUE	
PLEASE FILL OUT THIS SIDE OF THE CARD AND SEND TO LABORATORY WITH SPECIMEN	
Date	July 18, 1949
Patient's name	Mary Doe
Address	305 Quivira
Age	30
Sex	F
Occupation	Teacher
Physician's name	John Smith, M. D.
Address	1550 S. Harvard
Specimen to aid diagnosis	<input checked="" type="checkbox"/> Contact <input type="checkbox"/> Release <input type="checkbox"/>
Examination of food handler	
Condition suspected	Typhoid
Widal Report	None
When	
Vaccinated against typhoid	Yes
When	June 1929
To	John Smith, M. D.
Address	1550 S. Harvard
	Albuquerque, N. Mex.

- (2) Urine examination - Use feces card by marking out feces and writing urine
- (3) Specimen for vermicularis (pinworm, seatworm, threadworm)

This worm is sometimes placed in the genus Oxyuris

- (a) Order special cellophane-tipped swab in tube and container with form

f. Gonococcal Examination

- (1) Sample form

- (a) Three copies accompany specimen to laboratory, and report is returned on one of carbon copy forms

COMPLETE ALL FORMS CAREFULLY AND LEGIBLY <small>(USE TYPEWRITER OR PRINT WITH HARD PENCIL)</small> STATE PUBLIC HEALTH LABORATORY UNIVERSITY OF NEW MEXICO ALBUQUERQUE, NEW MEXICO		PHYSICIANS—DO NOT FILL OUT THIS SIDE GONOCOCCAL EXAMINATION NEGATIVE <input type="checkbox"/> POSITIVE <input type="checkbox"/> DOUBTFUL <input type="checkbox"/> <small>(A negative or doubtful report is of little value as an aid to diagnosis)</small>																																				
Patient's Name <u>John Doe</u> Address <u>Albuquerque 305 Quivira</u>		MICROSCOPIC EXAM.																																				
Age <u>24</u> Sex <u>M</u> Marital Status: Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Occupation <u>Student</u> Race: Anglo <input checked="" type="checkbox"/> Sp. Amer. <input type="checkbox"/> Black <input type="checkbox"/> Ind. <input type="checkbox"/> Purpose of Test: Aid to Diagnosis <input checked="" type="checkbox"/> Check on Treatment <input type="checkbox"/> Prenatal <input type="checkbox"/> Source: Vagina <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra <input checked="" type="checkbox"/> Bartholin's Gland <input type="checkbox"/> Skene's Gland <input type="checkbox"/> Eye <input type="checkbox"/> Clinical Diagnosis <u>Gonorrhea</u> Date of beginning of symptoms <u>June 1949</u> Condition: Acute <input checked="" type="checkbox"/> Chronic <input type="checkbox"/>		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th></th> <th style="writing-mode: vertical-rl; transform: rotate(180deg);">CERVIX</th> <th style="writing-mode: vertical-rl; transform: rotate(180deg);">URETHRA</th> <th style="writing-mode: vertical-rl; transform: rotate(180deg);">GLAND</th> <th style="writing-mode: vertical-rl; transform: rotate(180deg);">VAGINA</th> <th style="writing-mode: vertical-rl; transform: rotate(180deg);">EYE</th> <th style="writing-mode: vertical-rl; transform: rotate(180deg);">UNKNOWN</th> </tr> <tr> <td>Gram-negative intracellular diplococci</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Suspicious Gram-neg. extracellular diplo.</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Pus cells</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Miscellaneous organisms</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>			CERVIX	URETHRA	GLAND	VAGINA	EYE	UNKNOWN	Gram-negative intracellular diplococci							Suspicious Gram-neg. extracellular diplo.							Pus cells							Miscellaneous organisms						
	CERVIX	URETHRA	GLAND	VAGINA	EYE	UNKNOWN																																
Gram-negative intracellular diplococci																																						
Suspicious Gram-neg. extracellular diplo.																																						
Pus cells																																						
Miscellaneous organisms																																						
Date Received _____ Lab. No. _____		CULTURE																																				
Report to: <u>John Smith, M. D.</u> <u>1550 S. Harvard</u> <u>Albuquerque, New Mexico</u>		Negative Gram-negative oxidase positive diplococci culturally like gonococci isolated Gram-negative oxidase positive diplococci isolated. Not confirmed by sugars. Gram-negative oxidase positive diplococci isolated. Unable to confirm or deny.																																				
<div style="writing-mode: vertical-rl; transform: rotate(180deg); font-size: small;"> PLEASE TYPE OR PRINT NAME AND RETURN ADDRESS IN THIS BOX </div>		M. Greenfield Laboratory Director.																																				
		Date of Report _____ SYMBOLS: NEGATIVE — DOUBTFUL ± POSITIVE +																																				

- g. Rabies Examination
 (1) Head of animal
 (a) See Rabies, Part V
 (2) Sample form

RABIES EXAMINATION	
STATE PUBLIC HEALTH LABORATORY UNIVERSITY OF NEW MEXICO, ALBUQUERQUE	
Owner's Name	Mary Doe
Address	305 Quivira Albuquerque
Physician	John Smith, M. D.
Kind of animal	Dog, Cocker Spaniel
Persons probably inoculated by animal	One child
Animals bitten	None
History given	Dog refused to eat, was restless, died at 6 p.m. June 14.
Report to	Dept. Bernalillo County Health
Address	Albuquerque, New Mexico

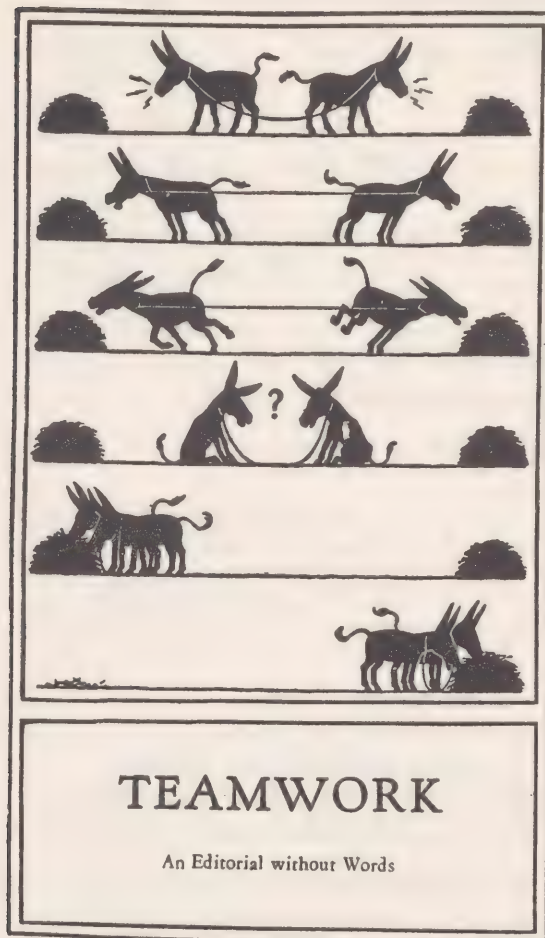
- h. Sputum Examination
 (1) For tuberculosis, bronchiectasis,
 pneumonia, other
 (2) Sample form

SPUTUM EXAMINATION	
STATE PUBLIC HEALTH LABORATORY UNIVERSITY OF NEW MEXICO, ALBUQUERQUE	
Please fill out this side of card and send to laboratory with specimen	
Patient's name	John Doe
Address	305 Quivira Albuquerque
Age	29
Sex	M
Occupation	Grocer
Anglo	<input checked="" type="checkbox"/>
Sp. Amer.	<input type="checkbox"/>
Black	<input type="checkbox"/>
Purpose of Test: Aid to Diagnosis	<input checked="" type="checkbox"/>
Check on Treatment	<input type="checkbox"/>
Release	<input type="checkbox"/>
License	<input type="checkbox"/>
Clinical Diagnosis: Tuberculosis	<input checked="" type="checkbox"/>
Bronchiectasis	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>
Other	<input type="checkbox"/>
Examination desired: Direct	<input type="checkbox"/>
Concentration	<input type="checkbox"/>
Culture	<input checked="" type="checkbox"/>
Animal Inoculation	<input type="checkbox"/>
Report to	John Smith, M. D.
Address	1550 S. Harvard Albuquerque, New Mexico

i. Urine Examination

.(1) See explanation under e. Feces

Y. TEAMWORK - AN EDITORIAL WITHOUT WORDS*



*Reprinted from the American Journal of Nursing, Vol. 28, June 1929, p. 587. By permission of the American Journal of Nursing.

ACKNOWLEDGMENT

We wish to thank the many authors and publishing firms for permission to use excerpts from their books and publications in the preparation of this manual as shown in the footnotes.



WY 108 qN556m 1949

54230940R



NLM 05285980 6

NATIONAL LIBRARY OF MEDICINE